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Cultural Diversity Series:

Meeting the Mental Health Needs of Asian and Pacific Islander Americans

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Introduction to the *Cultural Diversity Series*

The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences, and assessing the mental health system's success in addressing cultural differences.

As the 21st century gets under way, state mental health agencies face the growing challenge of accommodating an increasingly diverse and evolving constituency. The call to provide appropriate and accessible mental health services to all consumers—regardless of color, ethnicity, national origin, language, race, religion, age, disability, gender, sexual orientation, or socioeconomic standing—challenges state mental health agencies to develop effective, culturally competent services and treatment methods. As the U.S. population changes dramatically, so does the public mental health system consumer base. Immigration is now the nation's major source of population growth. More than 1 in 4 Americans (27 percent) are non-White and/or Latino. The U.S. Bureau of the Census (May 1996) projects that by the year 2050, nearly 1 in 2 Americans (47 percent) will be non-White and/or Latino. Mental health staff may be unprepared for differences in language and worldview, and even less prepared, for example, to support a gay inpatient consumer facing prejudice from other staff or residents or to provide crisis intervention to a consumer who is deaf or has another disability. However, local and/or federal statutes may require appropriate service provision to these persons.

The *Cultural Diversity Series* attempts to provide basic information and guidelines regarding the needs of a variety of ethnic and nonethnic minorities. Each of these technical assistance reports provides a synopsis of the particular population's mental health needs, relevant cultural characteristics and traditions, perceptions about mental illness, and preferences for services and supports. Each report also describes several mental health programs that have successfully tailored their services to meet the needs of diverse consumers and contains a comprehensive resource section with recommended readings and organizational resources.

The goal of the *Cultural Diversity Series* is to assist state mental health agencies in moving toward mental health service delivery systems that are appropriate and accessible to all consumers. This report explores ways to develop culturally competent public mental health systems and services for Asian and Pacific Islander Americans. Future reports will focus on American Indians and Native Alaskans, and persons who are deaf. The following reports in this series are available from the National Technical Assistance Center for State Mental Health Planning (NTAC): *Creating Culturally Competent Systems of Care for Latinos: Perspectives from an Expert Panel, Meeting the Mental Health Needs of African Americans,* and *Meeting the Mental Health Needs of Gay, Lesbian, Bisexual and Transgender Persons*.

Disturbing Service Utilization Trends

Despite their growing numbers, members of ethnic and racial groups are often underserved or inappropriately served by the public mental health system. Research suggests that various ethnic groups underutilize mental health services, either by dropping out of services or by entering services at much later stages in their illness, thereby creating a need for more costly services (Lefley, 1990; Munoz & Endo, 1982). For example, studies have found that although African Americans, Native Americans, and Latinos/Hispanics in most states underutilize community-based services, they are significantly overrepresented in state inpatient facilities (Aponte, 1994).

In anticipation of increased future service demands by growing ethnic minority populations, state mental health agencies are increasingly examining their accessibility to both ethnic and nonethnic minorities. State mental health agencies may be able to reduce the use of costly inpatient services by engaging ethnic minorities during earlier stages of their mental illnesses. More important, by providing culturally competent community-based services to all minorities, mental health decisionmakers can minimize human distress.

Cross-Cultural Mental Health Services and Barriers to Service Delivery

Cross, Bazron, Dennis, and Isaacs (1989) view culture as encompassing "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group." Cross-cultural mental health service delivery occurs whenever two or more of the participants are culturally different. Thus, Atkinson, Morten, and Sue (1998) point out that cross-cultural service delivery occurs, for example, in "a counseling dyad consisting of a low-acculturated Mexican American client and a high-acculturated Mexican American counselor." Similarly, a married heterosexual service provider brings a vastly different world view and set of experiences to the counseling relationship than a single client who is lesbian. Policymakers and service providers are coming to understand that cultural diversity must be broadly defined to accommodate wide variations among consumers.

Cultural differences exist on many levels, including help-seeking behaviors, language and communication styles, symptom patterns and expressions, nontraditional healing practices, and the role and desirability of medical intervention (Comas-Diaz & Griffith, 1988; Gaw, 1993). Members of ethnic and nonethnic minorities may be underserved by the public mental health system for varied and complex reasons. Some commonly cited factors include the following:

- the stigma of mental illness and the varying ways that members of different ethnic minority groups may define mental health and mental illness;

- lack of culturally appropriate services to accommodate the needs and beliefs of diverse consumers;
- consumer fears of experiencing discrimination in the treatment setting;
- mental health providers' lack of awareness or knowledge regarding culturally appropriate policies and practices;
- language barriers increased by the growing numbers of both consumers and providers whose native language is not English;
- communication barriers based on differences in verbal and nonverbal styles that may lead some minority consumers to feel they have given very clear messages to providers who have not understood the communication;
- lack of familiarity with Western or mainstream mental health services;
- fear of exposure or discomfort about disclosing sexual orientation or gender identity concerns to service providers; and
- systemic barriers, such as funding sources that place strict limits on reimbursable services.

Cultural Competence

Developing cultural competence within a mental health system is a dynamic and evolutionary process. The fundamental precepts of cultural competence include respecting and valuing differences among consumers, assuming responsibility to address these differences, and assessing the mental health system's success in addressing cultural differences. A culturally competent approach to services requires that agencies examine and potentially transform each component of mental health services, including assessment, treatment, and evaluation (Miller, Peck, Shuman, & Yrn-Calenti, 1995). The authors identify six stages of developing cultural competence:

Stage 1:	Sees other cultures as inferior: seeks to destroy other cultures.
Stage 2:	Cultural incapacity: adopts paternalistic posture toward so-called inferior people.
Stage 3:	Cultural incapacity: seeks to assimilate differences, ignore strengths.

Stage 4: Cultural precompetence: realizes weaknesses and makes commitment to improve.

Stage 5: Culturally competent: respectful, accepting, self-monitoring.

Stage 6: Takes advocacy and educational role.

Developing respect for differences and cultivating successful approaches to diversity requires increased awareness—of one's self; of unstated institutional cultural norms; and of the history, culture, and needs of diverse consumers. To increase cultural competence, mental health service providers need to develop an awareness of their own racial and cultural heritage; to understand how that heritage influences their understanding and biases about normality/abnormality and the process of mental health service delivery; and to understand the significant impact of differences both in language and in verbal and nonverbal styles on the process of communication (Atkinson et al., 1998). Mental health systems typically operate on unstated Western principles—such as, for example, the primacy of the individual over the group, a focus on competition and achievement, separation of the mind and body, and devaluing of altered states of consciousness—which may be at odds with the underlying values and beliefs of some ethnic and racial populations. Without awareness of this dynamic, mental health providers may impose this Western framework on minority consumers.

The populations that are the subject of these reports have all experienced and/or are experiencing some form of social inequity that is directly relevant to their status as underserved groups. Exploring and sometimes challenging the assumptions and biases held by stakeholders and the wider community is a crucial step toward achieving a culturally competent system. These attitudes have a direct impact on the functioning of minorities, their mental health needs, and their willingness to seek services. Similarly, cultural assumptions affect the mental health system, its practitioners, and its ability to engage minorities.

Some mental health systems and providers seeking to increase cultural awareness may inadvertently rely on overgeneralizations that ignore subgroup and individual variation, thus belying the basic value of cultural competence. To be truly culturally competent, mental health systems must be aware of significant differences in lifestyle and worldview among diverse populations, while valuing and responding to the distinct needs of each client. Rather than relying on stereotypes about groups, administrators and practitioners need to be aware of their own cultural assumptions and to ask consumers how *they* understand their problems and what *they* need.

These reports are designed to help key decisionmakers wrestle with the challenges facing public mental health systems, while effectively addressing the need for individualized, culturally competent services for ethnic and nonethnic minorities.

A closer look at: **Refugees**

People seeking refuge in the United States come from all ethnic and racial backgrounds, and they often have great difficulty obtaining traditional mental health services. These individuals have often experienced severe stress, resulting from continuous threat to life or freedom, traumatic flight, death of family members or friends, torture and imprisonment, living in concentration or refugee camps, uncertainty and lack of control over relocation, and inability to return to their homeland (Garcia-Peltoniemi, 1991). Their mental health may be jeopardized by multiple losses (of country, family, status) and other major disruptions (e.g., unemployment) that often accompany resettlement in a new country. A proportional number can be expected to be sexual minorities, or deaf or disabled, and the meaning and impact of these attributes will vary widely by culture.

Unfortunately, definitive prevalence rates of mental illness among refugees are elusive. The few studies available reveal that depression, anxiety, and posttraumatic stress disorder are reported at disproportionately higher rates in refugee populations. In addition, a small percentage of refugees experience schizophrenia or brief reactive psychoses marked by delusional content strongly related to culture that may require prolonged, intensive intervention (Garcia-Peltoniemi, 1991). Typically, state mental health agencies have contact with refugees during times of crises through crisis counseling services or inpatient treatment. Successful strategies to engage refugees prior to the eruption of crises include the following:

- networking with and through the refugee community;
- conducting home visits;
- linking with physical health services;
- using bicultural professional and paraprofessional staff; and
- making outreach efforts that focus on helping refugees meet basic needs, such as housing and income.

Such services are accepted more easily when linked with resettlement agencies (e.g., religious-based organizations, private organizations, state agencies or ethnic organizations that assist individual refugees upon arrival), and mutual assistance associations in which former refugees and immigrants help their own people. The Center for Mental Health Services' Office of Refugee Mental Health serves as a bridge between the mental health and refugee communities, providing consultation and training to states and refugee organizations.

A closer look at: Non-English-Speaking Consumers

The challenge of developing culturally competent mental health services is complicated by the vast number of languages that are spoken in the United States. Mental health providers may have difficulty reaching, communicating with, and treating non-English-speaking and/or deaf consumers, who exist within all communities.

Ideally, bilingual mental health professionals will be available to engage and provide treatment to people whose primary language is other than English. However, the need for academically trained, multilingual and multicultural mental health professionals far exceeds the number now available. While increasing the numbers of these professionals is essential, other models of services are also in use, including the following:

Bilingual Paraprofessionals. While they may not have formal clinical training, bilingual workers serve many valuable functions, including translator, paraprofessional counselor, culture broker, outreach worker, community educator, community advocate, and trainer of service providers about the refugee's culture (Egli, 1987). Ultimately, the goal may be to encourage bilingual workers to obtain further academic training in mental health to increase the supply of bilingual and bicultural psychiatrists, psychologists, social workers, and other mental health professionals. It should be noted that persons who can communicate in both American Sign Language and a spoken language are considered bilingual.

Interpreters. Using interpreters for assessments and treatment is a less desirable route, but one that many systems rely upon given the shortage of bilingual mental health professionals. As Adkins (1990) noted, "A facility with language does not make a person an effective interpreter unless there has been adequate training, agreement on interpretation system, and building of rapport between the mental health professional and interpreter." Thus, relying on family members to serve as interpreters is considered inadequate and inappropriate.

Executive Summary

Asian and Pacific Islander Americans (APIs) are generally viewed as the "model minority," possessing numerous strengths and facing few challenges. Contrary to the widespread perception that they are a well-adjusted group with few needs, however, research indicates that Asian and Pacific Islander Americans face significant mental health problems as well as difficulty in gaining access to appropriate mental health services. This report describes the cultural characteristics and mental health needs of the Asian and Pacific Islander American community, discusses barriers to mental health care, and provides recommendations for the development of policies and programs to better address the mental health needs of this population.

Demographic Characteristics

Representing 4.1 percent of the U.S. population, according to the U.S. Census Bureau, Asian and Pacific Islander Americans are the fastest growing racial/ethnic group in the United States as well as among the most diverse. Individuals in this population come from 43 different Asian and Pacific Islander groups and speak at least 32 different languages. They are also educationally and economically diverse. Although some Asian and Pacific Islander Americans have attained high levels of education and income, many live below the poverty line and many have not completed high school. Members of this group reside mainly on the East and West Coasts and in Hawaii, often in large urban centers. They are mostly foreign born, they often marry members of other ethnic groups, they often regard religion and spiritual practice as important in their lives, and they are on average younger than other population groups in the United States.

Major Mental Health Concerns

Because no large-scale mental health prevalence studies of Asian and Pacific Islander Americans have been conducted, it is difficult to specify the rate of mental health disorders within this population or to compare these rates with those of other population groups. However, available research indicates that the major mental health concerns of this population include depression, somatization, suicide, posttraumatic stress disorder, anxiety disorders, schizophrenia, certain addictive behaviors, and culture-specific syndromes. Factors that may affect mental health status include migration and postmigration stress, political status stress, communication barriers, acculturation stress, family role reversal, prejudice, racism, discrimination, and socioeconomic concerns such as work and financial stress.

Cultural Characteristics Relevant to Mental Health Needs and Utilization Patterns

The beliefs and behaviors of Asian and Pacific Islander Americans relating to mental health and mental illness are shaped by culture, acculturation experiences, and culturally based strengths. Because many

members of this population subscribe to a more holistic view of mind and body, for example, mental distress may be experienced through physical symptoms. Culturally based explanations for mental illness may include imbalances or excesses in life energies, punishment for past or present transgressions, and weakness in character. It is important to note, however, that the conceptualization and expression of mental disturbance may also change as members of this population become more "Americanized" and depart from traditional Asian values and ways of thinking. Recognizing API community strengths such as strong work ethics, family ties, and community cohesion can also help mental health providers to better understand service utilization patterns and to better serve this population.

Barriers to Adequate Care

Although members of this population often underutilize mental health services and drop out of treatment prematurely, they also are likely to exhibit more severe disturbances compared with other U.S. ethnic groups. This pattern suggests that Asian and Pacific Islander Americans are likely to endure longer periods of psychiatric distress before coming to the attention of the public mental health system. Barriers to adequate care include language barriers, cultural inhibitions such as stigma and shame about seeking mental health services, lack of accessibility to culturally appropriate services, and a shortage of culturally competent personnel. Furthermore, the problem of providing culturally appropriate care to Asian and Pacific Islander Americans may be exacerbated by the constraints inherent in the managed care behavioral health systems that serve them.

Moving Toward Culturally Competent Mental Health Systems

Providing culturally competent services to Asian and Pacific Islander Americans means considering cultural and sociopolitical factors in both assessment and treatment. Providers should investigate the efficacy of traditional assessment methods as well as incorporate cultural, social, political, family, and community influences in the assessment of APIs. With regard to treatment, research indicates that although many treatment strategies are effective with this group, family therapy has been consistently recommended to accommodate Asian and Pacific Islanders' family-centered orientation. Practical treatment strategies for working with immigrant Asian and Pacific Islander families are also described in this report.

Ensuring culturally competent mental health systems of care also requires multilevel interventions that involve planning and administrative leadership at the federal, state, and local levels. Although recent national initiatives have begun to address the unmet mental health needs of the API population, more work is needed.

Recommendations for Mental Health Systems Change

Indeed, overcoming barriers to the provision of mental health services is a task that must be addressed at every level—federal, state, county, city, and community. However, efforts to improve mental health services for this population will not succeed without the support and partnership of the states. The following are recommendations for state mental health authorities:

- Conduct a statewide needs assessment of Asian and Pacific Islander American populations, gathering data that are disaggregated by subgroups within the overall API population.
- Develop and implement a statewide cultural competency plan that includes specific goals, policies, and procedures; adequate resources; and designates of staff responsible for plan implementation.
- Develop and/or support existing culturally competent mental health services. Examples of such service models include integrating mental health services with primary health care settings; providing mental health services in natural settings such as churches, schools, and community centers; and developing special programs to address problems frequently affecting Asian and Pacific Islander communities.
- Recruit API professionals for mental health leadership positions, particularly those with interest and expertise in cultural competence and who can provide leadership for developing and implementing plans to improve cultural competence.
- Empower Asian and Pacific Islander American consumers, family members, and community-based organizations to play a leading role in supporting the mental health agenda.
- Address mental health disparities through state legislation. For example, pending legislation in California would require key state agencies to study options for restructuring mental health funding and services.
- Provide leadership in developing a human resources strategy to address the shortage of bilingual and bicultural Asian and Pacific Islander American professionals in public mental health settings.
- Provide cultural competence training to agency managers and service providers.
- Advocate for increased funding for research on the clinical and cost effectiveness of culturally competent mental health services.

- Ensure that state-funded contractors provide culturally competent care. Contractors must ensure adequate language accessibility to all API groups and demonstrate compliance with federal and state regulations; develop and implement an annual cultural competence plan with specific objectives and outcome measures; improve data collection concerning the Asian and Pacific Islander American population as a whole as well as subgroups within the API community; and ensure adequate funding and resources to address service disparities affecting the API community.

Model Programs

This report includes profiles of the following programs, which represent the state of the art in mental health services for API consumers:

- Richmond Area Multi-Services, Inc., a nonprofit, community-based, API-specific mental health agency serving the city and county of San Francisco.

- The Asian Pacific Development Center, a nonprofit, community-based, multiservice organization that is the only API-specific agency in Colorado.

- Hale Na'au Pono (House of Inner Balance), a nonprofit community mental health center that has received national recognition for its integration of Pacific (Hawaiian), Asian, and Western cultural traditions into mental health services.

Introduction

According to *Mental Health: A Report of the Surgeon General* (U.S. Surgeon General, 1999), racial and ethnic minority groups are underserved by the mental health system in the United States. Many barriers deter ethnic and racial minority group members from seeking treatment, and if individual members succeed in accessing service, the treatment may be inappropriate to their needs. In particular, Asian and Pacific Islander Americans (APIs) are less likely than Whites and members of other ethnic groups to seek mental health services. When they do receive services, linguistically and culturally competent services are not usually available.

The objectives of this report are to (1) identify the unique cultural characteristics and mental health needs of the API community; (2) address cultural, linguistic, socioeconomic, and geographic barriers to mental health care access and utilization; and (3) provide recommendations for the development of policies and programs to better address the mental health needs of API communities. The report is organized into six sections: (1) overview of Asian and Pacific Islander populations; (2) mental health problems and needs of this group; (3) cultural characteristics of Asian-American families; (4) concerns about current mental health service systems; (5) moving toward cultural competence; and (6) recommendations for systems-level change. The report includes samples of culturally competent clinical assessment and treatment strategies, and offers three descriptions of exemplary programs currently serving API communities.

Overview of Asian and Pacific Islander Populations

The term "Asian and Pacific Islander Americans" is used to describe residents of the United States who are from or whose ancestors were from the Asian-Pacific region. Far from being a homogeneous group, API is an umbrella term that covers at least 43 ethnic groups (Asian American Health Forum, 1990). Each group is unique in terms of ethnic origin, immigration history, language, acculturation rate, and educational attainment, among other variables.

There has long been dispute about the validity of combining such heterogeneous peoples together under one population grouping. The term "Asian and Pacific Islander" refers to such widely differing cultures and countries as India, Japan, Cambodia, the state of Hawaii, and the U.S. protectorates of Guam and American Samoa. Growing awareness of the complexity of racial and ethnic identity led the U.S. Census Bureau to include mixed-race options in the 2000 Census and to separate "Asian and Pacific Islander" into two groups. As a result, what was one racial/ethnic category in all major statistical reports until the year 2000 is now represented in multiple categories: Asian, Asian and Some Other Race, or Asian and a specified other race (each of which is listed separately); Native Hawaiian or Other Pacific Islander, Native Hawaiian or Other Pacific Islander and Some Other Race, or a specified other race. The more specific the information we have about diverse groups, the more appropriately public mental

health services can be designed and implemented. Not all analyses of the 2000 census data, however, are yet available. Accordingly, this report includes some available information from the 2000 census while also relying on statistical reports generated between 1990 and 1999 that aggregate Asian and Pacific Islander Americans as one group.

The overview below provides details regarding some of the unique characteristics of Asians and Pacific Islanders in America.

Demographic Overview

Asian and Pacific Islander Americans are the fastest growing racial/ethnic group in the United States in terms of percentage increase. U.S. Census data indicate that the API population grew 108 percent between 1980 and 1990, from 3.7 million to 7.5 million. The API population also had a higher growth rate between 1990 and 1999—45 percent—than any other racial or ethnic group (U.S. Census Bureau, 2000a). Projections from the returns on the 2000 Census are that the API population has reached 11.3 million, representing 4.1 percent of the population (U.S. Census Bureau, 2001a), with 75 percent of API population growth attributable to immigration. According to additional U.S. Census Bureau projections, the nation's API population may more than triple to 37.6 million by 2050. Under this scenario, the API share of the total population would climb from about 4 percent to 9 percent (U.S. Census Bureau, 2000b).

Asian and Pacific Islander Americans are the most culturally diverse minority in terms of country of origin. The term API refers to persons from 28 different Asian groups and 15 Pacific Islander groups (Asian American Health Forum, 1990). As of 1990, 95 percent of API persons in the United States were Asian Americans and 5 percent were Pacific Islanders. According to that year's census, the seven largest Asian-American groups were Chinese (22.6 percent of the API population), Filipino (19.3 percent), Japanese (11.7 percent), Asian Indian (11.2 percent), Korean (11.0 percent), Vietnamese (8.5 percent), and Cambodian (5.8 percent). Groups that made up less than 3 percent of the API population include Thai, Lao, and Hmong, among others (U.S. Census Bureau, 1990). The largest Pacific Islander population groups in the United States were Native Hawaiian (3 percent of the API population), Samoan (0.9 percent) and Guamanian or Chamorro (0.7 percent), with other smaller groups consisting of Tongan, Fijian, Palauan, Tahitian, Northern Mariana Islander, and other Pacific Islander populations (U.S. Census Bureau, 1993).

There are other Pacific Islanders who do not reside in the United States, but who live in island homelands throughout Polynesia, Micronesia, and Melanesia that are politically associated with the United States as territories, commonwealths, and freely associated states. In 1990, these combined U.S.-associated jurisdictions—including American Samoa, the Territory of Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, the Commonwealth of the Northern Mariana Islands, and the Republic of Palau—had a population of approximately 386,000 (Mokuau, 1998).

Asian and Pacific Islander Americans reside mainly in states along the East and West Coasts and in Hawaii. In 1999, most API persons in the United States (53 percent) resided in the West; 20 percent resided in Southern states; 18 percent in Northeastern states; and 10 percent in the Midwest (U.S. Census Bureau, 2000c). Approximately 75 percent of Pacific Islanders resided in California and Hawaii. California had more API residents than any other state—4 million. New York was a distant second (1.02 million), followed by Hawaii (753,691), Texas (577,306), and New Jersey (469,435). The states with the highest proportion of API residents were Hawaii (64 percent of the total population), California (12 percent), and Washington, New Jersey, and New York (6 percent each). Nevada, with 5 percent, had the sixth largest proportion of API residents—due to a 123 percent increase in API residents between 1990 and 1999. Other states with remarkable increases in their API population during that nine-year period include Georgia (109 percent increase), North Carolina (99 percent), and Florida (80 percent). Fully 29 states saw an increase of greater than 50 percent in their API population over the same period (U.S. Census Bureau, 2000d).

Asian and Pacific Islander Americans often live in large urban cities and counties. According to 1999 census estimates, 96 percent of API persons resided in metropolitan areas at that time—45 percent in cities and 52 percent in suburbs. Honolulu County, Hawaii, had the highest proportion of API residents (65%). The five counties in the United States with the highest numbers of API residents are all in urban areas. This tendency to cluster in urban centers could be due to refugee/immigrant relocation policies, availability of work, and/or access to known existing Asian or Pacific Islander communities. Los Angeles County, California, was the U.S. county with the highest number of API residents in 1998 (1.2 million). Honolulu County, Hawaii (566,000), and Orange County, California (361,000), ranked second and third (U.S. Census Bureau, 2000a). It is important to note that despite the high numbers of API persons in metropolitan areas, approximately one-third of Native Hawaiians and other Pacific Islanders in Hawaii reside in high-density rural communities on Oahu or neighboring islands (Brickling, 2001).

A high percentage of Asian Americans are foreign-born, although most Pacific Islanders are not. It is estimated that more than 65 percent of the API population in the United States are foreign born. Results of the 1990 U.S. Census showed that 92 percent of Vietnamese Americans were foreign born, along with 80 percent of Cambodians, 71 percent of Koreans, 64 percent of Filipinos, and 56 percent of Chinese (U.S. Census Bureau, 1990). More than one-fourth of the U.S. foreign-born population is from Asia. Four Asian countries were among the top contributors to the nation's foreign-born populations: the Philippines, China, Vietnam, and India (U.S. Census Bureau, 2000e).

In contrast, 1990 statistics show that only 13 percent of Pacific Islanders were foreign born (U.S. Census Bureau, 1993). Native Hawaiians are indigenous to the Hawaiian Islands, persons born in American Samoa are considered American nationals, and since 1950, inhabitants of the Territory of Guam have been U.S. citizens.

Asian and Pacific Islander Americans speak many different languages and dialects. Among members of Asian and Pacific Islander American groups, at least 32 different primary languages are spoken. Within each group, such as Chinese, Filipino, or East Indian, there are sometimes many dialects. Proficiency with English varies greatly among different groups and individuals. Most American-born Asians speak English with no accent and often do not speak the mother tongue of their parents' homeland. Similarly, many Pacific Islanders speak English, although a Creole dialect may interfere with English fluency. However, large numbers of foreign-born Asians and some Pacific Islanders struggle with English and continue to speak their primary language at home. As noted above, foreign-born persons constitute the majority of Asians living in the United States, thus posing a specific challenge for the provision of public mental health services.

Asian and Pacific Islander Americans are younger on average than most other population groups. According to data presented in the *Atlas of American Diversity* (Shinagawa & Jang, 1998), the median age for Asian and Pacific Islander Americans was 31.2 in 1998, four years younger than the national median age. Earlier data indicate that within the API population, Pacific Islanders were significantly younger, with a median age of 25 (U.S. Census Bureau, 1993). In 1999, children under 18 comprised 29 percent of the API population, while people age 65 and older constituted only 7 percent. For non-Hispanic Whites, the corresponding proportions were 24 percent and 14 percent (U.S. Census Bureau, 2000c). Thus providers of services to API communities need to pay special attention to the delivery of services to API children and youth. Also, relative youth in a population group may correspond to larger numbers of children and thus to larger families. In 1994, the average size of API families was 3.8 persons (4.1 for Pacific Islander families) compared with 3.1 persons for non-Hispanic White families; 73 percent of API families had three or more persons compared with 55 percent of non-Hispanic White families (Shinagawa & Jang, 1998; U.S. Census Bureau, 1993).

Research indicates a bimodal income distribution among Asian and Pacific Islander Americans. A common stereotype holds that API persons are typically high achievers in school and work. While some API individuals are very successful and do have high incomes, the stereotype obscures the needs of others and the range of diversity within this population. In 1998, the API population had the highest median household income of all the nation's racial groups: $46,637 (U.S. Census Bureau, 2000a). Yet many API persons live below the poverty line. In 1998, the poverty rate for the API population was 12.5 percent, compared with 8.2 percent for non-Hispanic Whites (U.S. Census Bureau, 1999). In API group comparisons, Southeast Asian refugees and Pacific Islanders have been found to be the most impoverished groups.

Research indicates a bimodal distribution in educational attainment among Asian and Pacific Islander Americans. In 1999, 42 percent of API persons age 25 and older had a bachelor's degree or higher, compared with 28 percent of non-Hispanic Whites. However, a slightly lower proportion of API (85 percent) than non-Hispanic Whites (88 percent) were high school graduates (U.S. Census Bureau, 2000c). Among API groups, Asian Indians have the highest proportion earning at least a

bachelor's degree (58 percent), while Tongans, Cambodians, Laotians, and Hmongs have the lowest (6 percent or less each). (Shinagawa & Jang, 1998)

Asian and Pacific Islander Americans often regard religion and spiritual practice as an important part of their lives. Major religions practiced by Asian Americans include Buddhism, Christianity, and Hinduism. Also, Confucianism may influence the family life of many Asians, particularly Chinese, Japanese, Korean, and Vietnamese Americans. Important influences for many Pacific Islanders are Christianity and/or traditional native religious or spiritual doctrines with a focus on relationships and the natural environment. Many traditional families believe in respect for spiritual teachers and family elders, worship in natural sites such as the mountains or ocean, and may place altars in the home and practice other rites of ancestor worship.

Asian and Pacific Islander Americans often intermarry with members of other ethnic groups. In 1990, 31.2 percent of all API husbands and 40.4 percent of all API wives were married to a person from a different race or ethnic group. Slightly fewer than 2 in 10 (18.9 percent) of API husbands were interethnically married, and slightly more than 1 in 10 (12.3 percent) were interracially married. Among women, Japanese American and Filipino American wives were the most likely to be intermarried (51.9 percent and 40.2 percent, respectively) (Shinagawa & Jang, 1998). There is a relatively large mixed-race population revealed in the 2000 Census. Of the 6.8 million people who reported more than one race, nearly 13 percent said they are "White and Asian" (U.S. Census Bureau, 2001b). Although Pacific Islanders reporting mixed-race identity constituted only 0.7 percent of the population that indicated more than one race, the majority (54 percent) of the Native Hawaiian and Other Pacific Islander population reported more than one race, with the most common combinations being with "Asian" and "White" groups (U.S. Census Bureau, 2001c). Providers need to be aware that cross-cultural communication and relationship issues may exist and need to be addressed within the API families they are serving, as well as between providers and consumers.

Immigration History

Examination of the history of Asian and Pacific Islander populations in the United States shows that immigration laws and policies have played an important role in the making and remaking of the various API communities. Family structures, vocational ambitions, residential patterns, political status, economic achievements, and community size all reflect the imprint of decades of political influence (Hing, 2000).

U.S. immigration law has had a major impact on the immigration of Asian Americans from 1982 to 1990. The ebbs and flows of Asian immigration history can be divided into three stages:

Before the Immigration and Nationality Act Amendment of 1965

Prior to 1965 the history of U.S. attitudes toward Asians and Pacific Islanders was characterized by both acceptance, motivated in large measure by a desire for cheap and dependable labor, and rejection, fueled by racial prejudice and fear of economic competition. Many state and local leaders supported the recruitment of Asian immigrants for work on railroads, mines, farms, and plantations, and as domestic help. Many of these same leaders also supported discriminatory rules restricting API persons' civil rights, land and business ownership, and access to naturalization. The Chinese Exclusion Act of 1882, for example, effectively slammed the door on Chinese immigration by suspending the immigration of Chinese laborers. In addition, the law barred Chinese naturalization and provided for the deportation of Chinese persons staying illegally in the United States.

In 1891, the passage of another Immigration Act represented the first passage of a comprehensive U.S. law for national control of immigration. In 1924, the Immigration and Naturalization Act established the first national origins quota system, which favored northern and western European immigrants.

World War II brought changes in these attitudes, and many Asians were allowed to become citizens after service in the U.S. armed forces. However, discrimination persisted. Following the Japanese invasion of Pearl Harbor, 120,000 Japanese Americans, many of them American citizens, were forcibly removed from their homes and confined in internment camps in violation of their constitutional rights.

After the Immigration and Nationality Act Amendment of 1965

This Act repealed the national origins quotas and established a seven-category preference system giving priority to immigrants with key skills and to reunifying families. It set a 20,000-per-country limit for the Eastern Hemisphere and imposed ceilings on immigration from Western Hemisphere countries for the first time. This law was enacted in a period of optimism during the Civil Rights movement. Its emphasis on family reunification set the stage for the development of sizable Asian American communities and provided the basis for dramatic increases in the number of immigrants from Hong Kong, Taiwan, the Philippines, India, Korea, and other locations.

The Indochina Immigration and Refugee Act of 1975

This law established the first permanent and systematic procedures for admitting refugees at the end of the Vietnam War. The vast majority of those who were permitted to enter the United States during the first wave were Vietnamese. By the late 1970s and early 1980s, this had changed to include more ethnic Chinese from Vietnam, Cambodians, and Laotians. These newer arrivals were usually considerably poorer and had less education than the first arrivals. The Southeast Asian refugee communities constitute the largest non-White, non-Western, non-English speaking group of people ever to enter the country at any one time (Hing, 2000). Many of these refugees had suffered torture,

psychological and physical trauma, and separation from or loss of multiple family members; predictably, high rates of posttraumatic stress disorder (PTSD) have been found in these refugee groups.

Special Issues for Pacific Islanders

Immigration laws and policies have differential impacts on Pacific Islanders based on the political relationship of island entities to the United States. The majority of Pacific Islanders in the United States are recognized as citizens or nationals because they are from the state of Hawaii or from U.S.-associated jurisdictions (e.g., Territory of American Samoa). Immigration laws and policies have had some impact on Samoans and Chamorros, even though the granting of national status and citizenship based on territorial designation has permitted traveling with relatively few restrictions. Prior to the 1965 Immigration and Nationality Act, there were some immigration restrictions for American nationals, but with the Act came a lifting of quota systems and the promotion of family reunification. Since that time, there have been periodic increases in Pacific Islander groups such as Samoans and Chamorros who join extended families already in the mainland United States.

Immigration laws and policies do not have an impact on Native Hawaiians who are indigenous to Hawaii. However, laws and policies related to the political relationship of Native Hawaiians to the United States, and the sovereign status of this population, are increasingly significant. In particular, the Apology Resolution of 1993 extends an apology on behalf of the United States to the Native people of Hawaii for the role of the United States in the overthrow of the Kingdom of Hawaii in 1893, and expresses a commitment to reconciliation efforts (Apology Resolution, 1993). This law and others can influence trends of future development within this population.

In summary, Asian and Pacific Islander Americans, a population group with greatly diverse origins and experiences, have a distinct history spanning more than 200 years in this country. The immigration or colonization history of each Asian or Pacific Islander American group is a unique and complex tale of change, adaptation, and survival. This history is in constant flux, as newer Asian immigrants reinvigorate established Asian communities.

Mental Health Concerns

Because no large-scale mental health prevalence studies of Asian Americans and Pacific Islanders have been conducted, it is difficult to specify the rate of mental health disorders within this population or to compare these rates with those of other population groups. Findings from available mental health research, however, strongly indicate that major mental health problems do exist among Asian Americans, contrary to the widespread belief that they are a well-adjusted group with little need for mental health services. There is preliminary information on the problems that exist within the Pacific Islander population, although the available research is uneven with regard to population focus, often region-specific, and sometimes descriptive and anecdotal.

Major Mental Health Concerns

Available research suggests that common mental health problems among Asian Americans and Pacific Islanders include depression, somatization, suicide, posttraumatic stress disorder, and anxiety disorders. Schizophrenia, culture-specific syndromes, addictive behaviors, and other mental health concerns will also be discussed below.

Depression

Depression has been widely found among Asian Americans, especially among immigrants and refugees. Chinese Americans in the San Francisco area, for example, have been found to have high rates of depression (Ying, 1988). In one study, more than one-third of a Chinatown adult sample acknowledged experiencing symptoms of emotional tension (Loo, 1989). Studies have shown higher rates of depression among Asian American college students than among Caucasian American students (Abe & Zane, 1990; Chang, 1996). One study of depression among Asian Americans (Kuo, 1984) found that Korean American immigrants had the highest incidence of depression, followed by Filipino, Japanese, and Chinese Americans, and that members of all four of these groups reported slightly more depressive symptoms than did Caucasian study participants.

Depression in Pacific Islander populations has been linked to other mental health problems such as substance use (Kameoka, Delva, & Watkins-Victorino, 1998) and suicide (Rubinstein, 1985). It has also been linked to migration experiences. One study found that 17 percent of 548 Chamorros who moved to California from Guam were at high risk for depression (Shimizu, 1982). Members of this high-risk group were characterized as female and widowed, with low educational attainment and low household income.

Studies at mental health clinics serving Southeast Asian refugees have consistently shown that these refugees constitute a high-risk group for depression (Beiser, 1988; Kinzie, 1989; Mollica, Wyshak,

& Lavelle, 1987; Westermeyer, 1988). Kinzie and colleagues (1990) reported that 82 percent of Southeast Asian refugee client samples suffered from depression.

There are also differences in mental health problems among Southeast Asian refugee groups (Rumbaut, 1985; Westermeyer, et al., 1989 a,b), with several studies finding the highest rates of depression among Hmong participants. For example, Mollica and colleagues (1987) found that 71 percent of refugee clients suffered from a major affective disorder and that Hmong study participants exhibited the highest rate (85 percent). In a large study in California, 55 percent of Hmong respondents were found to have high scores on a measure of depression, compared with 20 percent of Chinese-Vietnamese, 30 percent of Vietnamese, 36 percent of Cambodians, and 39 percent of Laotians. Another study found that 50 percent of the Hmong had high scores on a measure of high "psychosocial dysfunction" in comparison with only 15 percent of Chinese-Vietnamese (Gong-Guy, 1987).

The Hmong are an ethnic group that has lived in rural areas of several different countries for the past 5,000 years, with a long history of remaining independent from any particular country. Due to Hmong collaboration with the United States during the war in Vietnam, the majority of Hmong in Laos lost their homes, their land, their way of life, and many family members during the course of a prolonged and traumatic resettlement. Those who emigrated to the United States have been mostly relocated to urban environments despite their long history as an agrarian people. High rates of psychological distress among members of this population are likely to be caused by their profound losses, multiple traumas, the acculturation stress caused by relocation to urban U.S. communities, and conflicts between traditional and Western values.

Somatization

Many Asian Americans manifest their psychological problems as physical complaints such as headaches, weakness, or back and chest pain. Several research findings have reported high rates of somatic symptoms among Asian Americans (Kleinman, 1988; Marsella, Kinzie, & Gordon, 1973). Asian Americans have reported more somatic complaints than European Americans on the Minnesota Multiphasic Personality Inventory (MMPI), even when Asian Americans and European Americans have mental disturbances of equal severity (Sue & Sue, 1974). Chinese American students have been found to exhibit a definite pattern of somatic complaints (Marsella et al., 1973). It is important for providers to be aware of this pattern of symptom expression in order to detect possibly obscured mental health concerns. Culturally competent providers may need to educate physicians and other health care professionals so that they can make appropriate referrals for consumers seeking medical care because of somatically expressed mental health concerns.

Suicide

Suicide is not uncommon among Asian Americans. Asians are generally raised with a deep sense of

obligation and expectation to achieve, and many are taught to repress their emotions and focus on the needs of others or of the family. Internalizing anger, guilt, and shame without strong coping mechanisms for resolving them can lead to self-destructive feelings.

Among Asian Americans, young people and the elderly appear to be at the highest risk for suicide. In a study of the percentage of all deaths of 15- to 24-year-olds attributed to suicide, Chinese and Japanese Americans had a higher rate than Caucasian Americans. The rate for Chinese American females was 20.8 percent, compared with 8.8 percent for Caucasian American females (Yu, Chang, Liu, & Fernandez, 1989). Concerns about suicide among the elderly were first reported in a 1973 study in San Francisco's Chinatown (Bourne, 1973), where the suicide rate found among Chinese respondents was three times higher than the reported national average. Lonely elderly men who came to the United States as sojourners and who were struggling with physical illnesses constituted a high-risk group.

Within the Pacific Islander population, preliminary data indicate that Native Hawaiians in Hawaii and members of other native groups residing in their U.S.-associated island homelands, such as the Federated States of Micronesia, exhibit high rates of suicide. In one survey of more than 4,000 adolescents in Hawaii, Native Hawaiians had higher rates of attempted suicide (13 percent) than other youth (10 percent), with risk linked to such factors as depression, substance abuse, grade level, and cultural affiliation(Yuen, Nahulu, Hishinuma, & Miyamoto, 2000). Epidemic rates of suicide have been noted among Micronesians, with estimates for young men at 100 per 100,000 in comparison with approximately 20 per 100,000 for American men between the ages of 15 and 24 (Rubinstein, 1985). Explanations include cultural perspectives on suicide as well as rapid social change influenced by U.S. occupation.

Posttraumatic Stress Disorder (PTSD)

During the past five decades, Asian Americans who immigrated from Asian countries have experienced many types of traumatic events caused by years of war and political turmoil. Many of them have experienced torture, forced labor, internment, sexual abuse, starvation, forced migration, and multiple losses—and for many these traumas may have started in childhood and/or continued for many years. Such severe traumatic experiences predispose survivors to PTSD. Many exhibit common PTSD symptoms such as insomnia, nightmares, flashbacks, hypervigilence, psychic numbing, overwhelming anxiety, guilt, and depression. Upon their arrival in the United States, refugees face additional challenges such as language barriers, unemployment, and fragmentation of social support.

PTSD is exhibited relatively frequently by Southeast Asian refugees and can persist for decades (Kinzie et al., 1990). Rates of PTSD found among nonclinical samples of Southeast Asians have ranged from 10 percent to nearly 90 percent (Gong-Guy, 1987). PTSD has been found to be persistent among

Cambodian patients (Kinzie, 1989). It also affects other immigrant populations that experienced trauma during periods of war and civic unrest, such as the Cultural Revolution in China in the 1970s.

Anxiety Disorders

In contrast to psychotic disorders, anxiety disorders are more influenced by sociocultural factors in terms of how the disorders are diagnosed and treated. Although no epidemiological data were found on the rate of anxiety disorders among Asian Americans, related studies indicate that anxiety is a concern in working with this population, as is its accurate diagnosis and treatment. Kuo's (1984) study on depression revealed significant levels of anxiety symptoms among Chinese American participants. Studies in a Toronto clinic, on the other hand, found the rate of anxiety disorders among the Chinese patients to be roughly the same as among the mainstream population (Lo & Lau, 1997). Sue and Kirk (1973) found that students under pressure and carrying high expectations display more symptoms of anxiety. A study of anxiety levels found that Chinese Americans expressed significantly more discomfort than did their control counterparts. This study also revealed that recent immigrants were more likely to experience anxiety than immigrants who had been in the United States longer (Sue & Zane, 1985).

Providers should be aware of several special diagnostic and assessment concerns in working with Asian Americans with symptoms of anxiety. Social phobia, for example, appears to be more prevalent among Asian Americans than among other groups, but it is often misdiagnosed in members of this population as paranoid psychosis, personality disorder, and other disorders due to lack of cross-cultural diagnostic skill. Anxiety disorders are also difficult to diagnose because anxiety may occur as a symptom of many other disorders such as somatization, depression, or neurasthenia. Accurate assessment of mental health symptoms is made more difficult by the lack of culturally competent psychometric assessment instruments (Lo & Lau, 1997).

Schizophrenia

No studies were found examining the prevalence rates for schizophrenia among API Americans. However, two studies of mental health needs of Southeast Asian refugees have found higher rates of schizophrenia among refugees than among nonrefugee patients (Flaskerud, 1988; Kinzie, Sack, Angell, Clarke & Ben, 1989). Studies conducted in Asian countries indicate a slightly lower lifetime prevalence of schizophrenia in Taiwan and Korea than in the United States (Gee & Ishii, 1997). One study at the only public psychiatric hospital in Hawaii noted that the Native Hawaiian patient population was slightly overrepresented (15 percent) when compared with the Native Hawaiian state population (13 percent); was predominantly male; and like other patients, had primary diagnoses of psychotic disorders (52 percent) including schizophrenia; mood disorders (29 percent) such as depression; and other disorders (19 percent) such as personality disorders (Crocker, Kakai, Mokuau, & Ewalt, 1995). In Asian and Pacific Islander cultures, people with schizophrenia are highly stigmatized and usually are viewed as bringing shame upon their families. Providers working with Asian and Pacific Islander American consumers and their families must take this strong stigma into account. The clinician should empathize with them and reassure them about confidentiality. In addition, antistigma campaigns in communities are needed.

Culture-Specific Symptoms

There is strong evidence that Asian Americans exhibit culturally distinct symptom patterns. Certain illnesses, known by their indigenous names, have been reported in many countries in Asia—including "koro," "hwa-byung," and "qi-gong psychotic reaction." "Koro" refers to anxiety reactions stemming from fear that the genitals will recede into the body and may cause death; this syndrome is usually found in Chinese and Southeast Asian cultures. "Hwa-byung," found predominantly in the Korean culture, means fire and anger illness. Attributed to the suppression of anger, symptoms may include a broad range of physical symptoms ranging from abdominal pain to poor eyesight. "Qi-gong psychotic reaction" describes an acute brief reaction to participation in the energy-based exercises of qi-gong (or chi-gong) that may include dissociative, psychotic, or other psychiatric symptoms (American Psychiatric Association, 1994).

Substance Abuse

Among Asian Americans. Although Asian American groups have been consistently left out of substance abuse epidemiological studies and Asian American-focused studies are scarce, certain significant findings are worth noting:

- Research suggests that Asian Americans in general use and abuse drugs and alcohol at lower rates than Caucasian, African, and Hispanic Americans (National Institute on Drug Abuse, 1995). This finding has promoted the mistaken notion that substance abuse is not an issue of concern among API Americans.

- The complexity of different cultural norms, languages, traditions, values, and beliefs among this population results in varying patterns of substance use or abuse among different subgroups. Each subgroup may differ not only in which drugs are used but also in how they are used (Kuramoto, 1994).

- Asian American groups vary in alcohol-use patterns. For example, in a study of alcohol use among four different Asian American groups in Los Angeles, the proportion of heavy drinkers was found to be highest among Japanese, followed by Filipinos, Koreans, and Chinese. On the other hand, researchers found the highest percentage of moderate drinkers among Chinese study participants, followed by Japanese, Filipinos, and Koreans. Koreans had the highest percentage of abstainers (Kitano & Chi, 1985).

- Asian Americans are less likely than other groups to seek treatment for substance abuse. Underutilization of services, however, is more likely to result from a lack of culturally competent services than from low levels of substance abuse among members of this population (Kuramoto, 1994).

- Community-based service organizations often are the only source of substance abuse treatment available to API Americans. Many of these organizations are willing to help but often are underfunded, ill trained, and ill equipped to provide effective substance abuse treatment (Kuramoto, 1994).

Among Pacific Islanders. There is accumulated evidence of high rates of alcohol and other drug use among Native Hawaiian adolescents and adults. A recent study of more than 25,000 students in Hawaii showed that Native Hawaiians in grades 6 through 12 report the highest use of alcohol and drugs in comparison with Caucasians, Filipinos, Japanese, and Chinese, and they are exposed to more risk factors and fewer protective factors (Klingle & Miller, 1999). This study echoes earlier findings that Native Hawaiian students had higher rates of alcohol and other drug use than students from other racial/ethnic groups in Hawaii (State of Hawaii Office of Children and Youth, 1994). Findings on adults are similar to those for adolescents in Hawaii. A review of the literature indicates higher proportions of alcohol use among Native Hawaiian and Caucasian populations than among Asian groups such as Japanese, Filipino, Chinese, and Korean (Hishinuma, Nishimura, Miyamoto, & Johnson, 2000). The use of substances among adult women is particularly troublesome, with Native Hawaiian and Puerto Rican women in Hawaii showing the highest rates of alcohol consumption during pregnancy and higher rates of birth defects (State of Hawaii Office of Children and Youth, 1994).

Smoking and Tobacco Use

As with alcohol and drug use, tobacco use varies significantly among Asian and Pacific Islander groups. Research shows that gender and acculturation have important influences on the smoking rates of Asian Americans. Asian Americans as a group appear to smoke less than White Americans or members of other ethnic minority groups, but these differences can be attributed largely to the low smoking rates of Asian American women. The smoking rate among Asian males is very high in many Asian countries. Asian American men, especially those who are foreign born and less acculturated, have smoking rates similar to those of White Americans. One study found that Vietnamese male youths smoked at rates similar to those of White male youths and exceeding those of both Hispanic and African American male youths; yet Vietnamese female youths had the lowest smoking rate in this study (Zane and Kim, 1998).

In research available on Pacific Islanders, indications are that smoking is a problem for both adolescents and adults. In the school survey of 25,000 students cited in the previous section, the use of tobacco, like alcohol and other drug use, was found to be higher among Native Hawaiian students than other racial/ethnic groups in Hawaii (Klingle & Miller, 1999). Tobacco smoking rates among Native Hawaiian adults are also higher than for other populations in Hawaii (State of Hawaii Department of Health as cited in Office of Hawaiian Affairs, 1998). It is further noted that Native Hawaiian and Samoan women smoke at higher rates than other racial/ethnic groups during pregnancy (State of Hawaii Office of Children and Youth, 1994).

Pathological Gambling

Pathological gambling is perceived by many Asian Americans to be the most severe addiction problem affecting their communities. A 1995 survey found that nearly 70% of 1,800 respondents in San Francisco ranked gambling as their community's number one problem, surpassing gangs and drugs (Jang, Lee, & Woo, 1998). Social services and law enforcement agencies in Asian communities also perceived problem gambling as perhaps the greatest problem confronting their communities. One social service agency in San Francisco's Chinatown, for example, has estimated that gambling underlies about one-third of the agency's domestic violence cases (personal communication, 1999). The interest of Asian Americans in gambling is also reflected in casino revenues. In a 1997 study of Las Vegas Strip casinos, Asians accounted for 17 percent of total table game revenues but 80 percent of the revenue at high-stakes table games. In what appears to be the only available study examining ethnic differences in gambling, Asian Americans were found to have the highest rate of gambling when compared with African Americans, Caucasians, and Native Americans (Leisieur et al., 1991).

Cultural factors inhibit many pathological gamblers from seeking treatment. Many Asian Americans view taking risks as a part of life and participating in games of chance as normal behavior. Gambling is considered by many to be a harmless and socially acceptable means of passing one's time. Compulsive gambling is widely regarded by Asian Americans as a weakness, not a medical disorder or addiction. Compounding the problem of promoting treatment is the scarcity of bilingual/bicultural programs for Asian American gamblers. In an effort to address the gaps in treatment and awareness, the Chinese Health Coalition in San Francisco offered a training certificate program to 25 mental health counselors in 1999, and Richmond Area MultiServices, Inc., started the city's first counseling program for problem gamblers and their families.

Other Psychological Concerns

In addition to the mental health problems and addictive behaviors noted above, Asian Americans may seek mental health support for a variety of other concerns. These may include low self-esteem; identity confusion; impaired interpersonal skills; paranoia; bipolar disorder; conduct disorder; eating disorders; and family problems such as intergenerational conflict, marital disharmony, in-law problems, domestic violence, and child and elder abuse and neglect. Some special stressors that may affect the mental well-being of members of this population are discussed below.

Special Stressors for Asian Americans and Pacific Islanders

Migration

For many Asian American immigrants and refugees, the stress of migration can result in psychological

strain, which in turn may jeopardize mental health. With few exceptions, Asian countries have suffered years of war and political turmoil. Many immigrants and refugees have experienced involuntary separations and exposure to trauma, both in their home country and in their search for sanctuary (Lin, 1986). To understand the full range of stress experienced by refugees, it may be helpful for providers to recognize and assess five types of losses commonly associated with refugee status. These are (1) material losses such as land, property, business, career, and money; (2) physical losses such as injuries, disfigurement, hunger, and malnutrition; (3) spiritual losses such as freedom to practice religion and support from faith communities; (4) loss of family members, relatives, and friends; and (5) loss of community support and cultural milieu (Lee, 1990).

Postmigration Stress and Culture Shock

In addition to the stress of migrating, postmigration stress and culture shock can prove overwhelming. Many immigrants find themselves in a strange and unpredictable environment. They have to adjust to physical changes (e.g., a new place to live, new housing arrangements, new communities), economic changes (e.g., unemployment and underemployment), cultural changes (different religious, educational, and social values), and relationship changes. For many there is a sudden lack of extended family support at a time when it is most needed. The new family unit, isolated for the first time, is responsible for making and maintaining its own set of rules and adjusting to a new environment with strange demands. When such stressors are extreme and the support system is ineffective, the individual is likely to experience emotional and mental problems.

Acculturation

For many Asian Americans, dealing with the contrast between their original culture and mainstream American culture can be difficult (Padilla, Nagatsuma, & Lindhom, 1985; Yu & Harburg, 1980). Lin, Matsuda, and Tazuma (1982) described five common adjustment patterns: (1) neurotic marginality (develops high levels of anxiety while trying to comply with expectations of both cultures); (2) deviant marginality (becomes isolated due to ignoring norms of both cultures after being unable to satisfy both simultaneously); (3) traditionalism (withdraws into the old culture to escape loss and confusion); (4) overacculturation (abandons former culture, loses traditional supports); and (5) biculturation (integrates both cultures with the best possible compromises). The greater the cultural dissimilarity between two cultures, the greater the acculturation stress. In addition, each family member may have a different level of acculturation within the same family, and intergenerational conflict may be triggered by this disparity. Many API adolescents face the complex task of straddling multiple cultures: the mainstream culture, the ethnic culture of origin, and teenage culture. For many, this task of balancing and integrating disparate values, attitudes, and behaviors may be filled with conflicts, adding to intergenerational tensions.

Political Status

Pacific Islanders who migrate to the United States from either U.S.-associated jurisdictions or other Pacific nations experience the same stressors of adjusting to a new host culture as others who move to the United States. They experience isolation and other factors of culture conflict that may promote or exacerbate behavioral or emotional problems. However, the political affiliation of Pacific island entities to the United States has also contributed to special and unique stressors for Pacific Islanders. The state of Hawaii and U.S.-associated jurisdictions such as American Samoa, the Territory of Guam, and the Federated States of Micronesia were initially sought by the United States because of the political importance of their strategic military locations. The development of these islands as major military bases has historically contributed to major socioeconomic and political changes that, in many ways, have adversely affected the native culture (Trask, 1989). Specific problems inherent in these changes, such as the loss of land, the disorganization of kinship/clan structures, and the lack of self-governance can have a negative impact on mental health. Therefore, mental health problems associated with cultural conflict, identity confusion, and marginalization may affect not only Pacific Islanders traveling to the continental United States but also those continuing to reside in their island homelands.

Communication

For many persons who are monolingual or have limited English-speaking skills, the inability to communicate well in English may cause tremendous stress. Aside from obvious and significant language barriers in the mental health care setting, different communication styles may also lead to misunderstandings. In counseling sessions, for example, some Asian American clients may appear quiet, passive, polite, and formal, and they may work to avoid direct confrontation or offending others. Silence and lack of eye contact may also be used as forms of indirect communication. Western clinicians may erroneously interpret these behaviors as signs of lack of attention or respect, or as symptoms of mood or personality problems. Thus the availability of bilingual, bicultural API clinicians and culturally competent interpreters is vitally important in treating monolingual or limited English-speaking API consumers.

Work and Financial Issues

Unemployment and underemployment can lead to low self-esteem, insecurity, and role reversal in API families. In addition, long hours at work or working multiple jobs can result in increased stress. Highly acculturated, professional Asian Americans may encounter the frustrations of a "glass ceiling" (an invisible barrier to promotion and success based on ethnicity or gender) or other subtle discriminatory practices.

For some Pacific Islanders, financial stresses may develop as a result of cultural conflicts in values and responsibilities. In Samoan culture, values related to love and mutual sharing guide behavioral

obligations. It is not uncommon for Samoans residing in the United States to regularly send one-third or more of their income to families residing in American Samoa, and to give large financial contributions for emergencies. The consequences of reduced income may, however, contribute to stress and emotional strain (Mokuau & Tauili`ili, 1998; Young & Galea`i, 1998).

Legal Problems and Sponsor Relationships

Because of language difficulties and lack of familiarity with U.S. immigration laws, many immigrants depend on their sponsors for legal, financial, and emotional support, especially upon arrival. The legal sponsor is often given a great deal of power in many family decisions. Sometimes, for example, a sponsor may object to a family's receiving assistance from a social service or mental health agency, fearing that doing so may jeopardize future sponsorships and bring shame to the family name. The family may feel both gratitude and resentment toward a sponsor's exercise of power, thus fostering a "hostile-dependent" relationship.

Family Role Reversal

In many Asian languages, no word exists for the pronoun "I." Life is seen as a complex web of relationships from which no individual is separate. Strongly prescribed family roles and great respect for elders and ancestors help keep the web strong. Family conflicts may emerge because of role reversals among grandparents, parents, and children that occur due to immigration (Charron & Robert, 1983; Lee, 1988). Many monolingual adults, for example, depend on their English-speaking children as culture brokers and interpreters, which may stimulate anger and resentment in members of both generations. Role reversal may also occur between husband and wife. Husbands accustomed to male-dominated Asian cultures may find it difficult to accept if their wives find work more easily or get paid more than they do, or simply become more independent and assertive.

High Parental Expectations

Many API adults had their careers interrupted by the immigration process, and they may wish for their children to achieve their unfulfilled dreams. Thus many children, adolescents, and young adults face very high expectations of academic and professional success, which may result in significant mental health problems (Sue & Zane, 1985).

Racism, Prejudice, and Discrimination

As a visible minority with distinctive physical features and accents, Asian Americans and Pacific Islanders do not generally have the option of "passing" (hiding their ethnic heritage) to achieve acceptance in American society. Many encounter racial discrimination in their workplaces, schools, and communities. Such discrimination affects not only recent immigrants but also well-educated and highly

acculturated Asian American professionals. Due to public ignorance about the diversity among API groups, many Asian and Pacific Islander Americans may experience subtle forms of discrimination as well—such as encountering the assumption that all individuals who appear Asian are Chinese or Japanese and are foreign born.

In spite of these stressors and challenges, most Asian Americans are resilient enough to succeed in society. But for some, particularly those who have been highly traumatized and are isolated without family and community support, these stressors may become overwhelming and may foster or exacerbate mental health problems.

In summary, the major mental health concerns of Asian and Pacific Islander Americans include depression, somatization, suicide, posttraumatic stress disorder, anxiety disorders, and schizophrenia. Some special stressors due to experiences related to immigration, colonization, or refugee status that may affect the mental well-being of Asian Americans include migration, post-migration, and political status stress; language barriers; acculturation stress; family role reversal; and other socioeconomic concerns. The next section describes cultural characteristics of Asian and Pacific Islander Americans that may have an impact on their understanding and utilization of mainstream mental health services.

Cultural Characteristics Relevant to Mental Health Needs and Utilization Partners

Conceptualizations of Mental Illness

Culture plays an important role in shaping health beliefs, coping strategies, help-seeking behavior, and conceptualizations of emotional difficulties and mental illness. Although many highly acculturated Asian Americans endorse more Western-oriented health beliefs and practices, many foreign-born immigrants and refugees in Asian American communities are guided by traditional religious and health beliefs. Additionally, it is commonly assumed that all people have the same basic mental processes, but recent findings in neurobiology indicate that this is not true (Castillo, 1997). Dispelling the assumption that all peoples' brains function in the same basic ways, despite differences in learning, memory, and cognition across cultures, has significant implications for understanding mental illness. First, it encourages an expanded cross-cultural understanding of illness, and second, it permits varying interpretations of people's subjective experiences of illness. It may be helpful to public mental health planners and providers to understand the belief systems and experiences that inform the way some API persons understand and respond to mental health concerns. Asian cultural explanations of some mental illnesses, such as schizophrenia and somatization, are discussed below.

Schizophrenia

Generally speaking, there are seven popular API cultural explanations of factors that may contribute to the development of schizophrenia (Lee, 1997):

- *Imbalance of "yin" and "yang," and disharmony in the flow of "qi."* In traditional Chinese medicine, humankind is viewed as a microcosm within a macrocosm. The energy ("qi") within each human being is interrelated with the energy of the universe. The presence of emotional problems is thought to result from an imbalance of "yin" and "yang" (bipolar life forces), or from an excessive accumulation of "qi" (life force energy).

- *Supernatural intervention.* Psychotic symptoms such as hallucinations and delusions are often seen as a form of spiritual unrest meted out to the individual through the agency of a "ghost" or vengeful spirit. From this standpoint, symptoms are a sign of punishment, most likely due to the transgression of family rituals in ancestor worship (Lin & Lin, 1980).

- *Religious beliefs.* Mental illness may be viewed as "karma" caused by deeds from past lives, or as punishment from God.

- *Genetic vulnerability or hereditary defects.*

- *Physical and emotional strain and exhaustion.* This can be caused by external stresses such as a business failure, ending of a love affair, or death of a family member.

- *Organic disorders.* Mental illness is conceptualized as a manifestation of physical disease, especially brain disorders, liver diseases, or hormonal imbalances.

- *Character weakness.* Mental health is achieved through self-discipline, exercise of will power, and the avoidance of morbid thoughts. It may be assumed that a person who is vulnerable to emotional problems, having been unable to develop this discipline, was born with a weak character.

Somatization

Somatization, the expression of mental distress as symptoms of physical illness when no organic cause for illness can be found, is common among Asian Americans. There is a strong belief in the unity of body and mind among Asian Americans, and this somatic process may grow out of a holistic view of the body and mind. Various organs are associated with different emotions. Joy, for example, emanates from the heart. Sorrow is associated with the lungs, anger with the liver, and fear with the kidneys. Emotional problems are frequently explained in traditional Chinese medicine as caused by weak kidneys or heart. Or, conversely, excessive emotions are thought to weaken the function of the associated organs. Thus consumers may believe that physical symptoms are an expression of emotional distress and/or may present for mental health services with physical complaints. However, mental health providers must be cautious in their interpretation of somatic complaints. Asian Americans who present physical symptoms may be suffering from genuine organic problems rather than a somatic expression of psychological stress.

Using the Hamilton Rating Scale for depression, Cheung, Lau, and Waldemann (1981) studied symptoms of depression expressed by Chinese patients at a primary care clinic. Among those who were depressed, the most frequently endorsed symptoms were "feeling tired and fatigued," "pains and aches," and gastrointestinal or cardiovascular symptoms. Tension, nervousness, agitation, and restlessness also were endorsed by a majority of the depressed group. None of the depressed patients came to the clinic with initial complaints of sadness, unhappiness, or depressed mood. From the traditional Chinese patients' perspective, their chief problem is not depression but "neurasthenia." Neurasthenia—a syndrome of exhaustion, weakness, and diffused bodily complaints believed to be caused by inadequate physical energy in the central nervous system (Kleinman, 1998)—is an official diagnosis in China and one widely used by traditional herbalists in Chinatowns in the United States.

Conceptualizations of Mental Illness in Pacific Islander Cultures

For many cultures of the Pacific, there is no direct translation for mental illness because emotional and psychological problems are often integrated holistically with biological, cognitive, and spiritual functions. In Native Hawaiian culture, "Hawaiians do not use the phrase 'mental illness' but instead state that *pilikia* (trouble) occurs" (Ginny Kinney, personal communication, February 1, 1996). Emotional and psychological concerns are viewed in a broader context as an imbalance that may be occurring in key relationships between the individual, family, natural, and spiritual realms (Andrade, 1989; Mokuau, Lukela, Obra, & Voeller, 1997). Similarly, in Micronesian culture, depressive emotions are understood to be connected to the loss of important relationships. The emotion *lalomweiu* (loneliness or sadness from the loss of a loved one) appears to be the closest thing to the Western idea of major depression (Castillo, 1997). Expanded notions of mental illness and wellness also encourage varying interpretations of people's subjective experiences. For example, the subjective experience of talking with deceased family members should not necessarily lead to a diagnosis of schizophrenia if providers understand that having visions of the dead is recognized as a part of grieving in Native Hawaiian culture (Pukui, Haertig, & Lee, 1972).

Values and Acculturation Levels

Members of the many different Asian and Pacific Islander American groups arrived in, or became part of, the United States at different times and for different reasons. Thus they exhibit varying degrees of acculturation, from the very traditional to very "Americanized." More traditional individuals or families identify with Eastern or Pacific native cultural values, while more acculturated ones identify with Western cultural values.

Some broad generalizations can be made about Eastern and Western values that may help readers to recognize differences in world view and behavioral expectations. Table 1 describes some of these differences (Lee, 1997). Note that these differences are intended to be generalizations that clearly do not apply to all individuals in each culture; rather, most people fall somewhere within this East-West continuum. Within any given Asian American family, in fact, it is likely that various family members may identify with different elements of each cultural perspective, depending especially on their ages and acculturation rates. Although these generalizations contrast Eastern and Western values, those delineated for the Eastern perspective have broad applicability for Pacific Islanders.

Table 1. Comparison of Eastern and Western Cultural Values

Eastern (agricultural) systems: Traditional society values	*Western (industrialized) systems: Modern society values*
Family/group oriented	Individual oriented
Extended family	Nuclear/blended family
Multiple parenting	Couple parenting
Primary relationship: parent-child bond	Primary relationships: marital bond
Emphasis on interpersonal relationship and harmony	Emphasis on self-fulfillment and self-development
Status and relationships determined by age and role in family	Status achieved by individual's efforts
Well-defined family members' roles	Flexible family members' roles
Favoritism toward males	Increasing opportunities for females
Authoritarian orientation	Democratic orientation
Suppression of emotions	Expression of emotions
Fatalism/karma	Personal control over the environment
Harmony with nature	Mastery over nature
Cooperative orientation	Competitive orientation
Spiritualism	Materialism, consumerism
Past, present, and future orientation	Present, future orientation

Within this continuum, there are numerous variations. A model has been proposed that describes five acculturation styles among Asian American families (Lee, 1997). These five family types are hypothetical constructs offered to help increase understanding of the complexity of Asian American families.

The Traditional Family

Traditional families usually consist entirely of family members who were born and raised in Asian countries and who continue to hold strong beliefs in the types of traditional Eastern values described above. They usually speak in their native languages and dialects at home and typically reside in ethnic Asian communities such as Chinatown, Koreatown, Japantown, or Little Saigon in major cities.

Historically, an agricultural economy and society and the teachings of Confucianism and Buddhism have had a profound influence on Eastern philosophical approaches to life and family interactions. In traditional Asian families, the family unit—rather than the individual—is highly valued. A person's actions reflect not only on that individual but also on his or her extended family and ancestors (Shon & Ja, 1982). An individual is expected to function in his or her clearly defined roles and positions in the family hierarchy, based on age, gender, and social class. Obligations and shame are the mechanisms that traditionally help to reinforce societal expectations and proper behavior. There is an emphasis on harmonious interpersonal relationships, interdependence, and mutual obligations or loyalty for achieving a state of psychological homeostasis or peaceful coexistence with family or other fellow beings (Hsu, 1971).

The "Cultural Conflict" Family

In these families, members hold different cultural values. A typical family in cultural conflict may consist of grandparents and parents with strong traditional beliefs (usually foreign born) living with a more acculturated and Americanized younger generation (typically born in the United States). This type of family experiences a great deal of stress caused by intergenerational conflicts. Another type of "cultural conflict" family is one in which the spouses have differing levels of acculturation or differing beliefs about the desirability of increased acculturation. Cultural conflicts can be caused not only by the varying degrees of acculturation of family members but also by religious, philosophical, or political differences.

The Bicultural Family

A majority of bicultural families are headed by highly acculturated parents who came to the United States many years ago for their education and are very familiar with American culture. Before arriving in the United States, they were likely to have lived in major Asian cities and to have been exposed to urbanization, industrialization, and Western culture. They may also have been born in the United States and raised in traditional families. The parents in bicultural families are typically middle and upper class

and hold professional jobs. They are bilingual and bicultural and thus are familiar with both Eastern and Western values.

The "Americanized" Family

Most of these families consist of parents and children who were born and raised in the United States. As generations pass, the roots of their traditional Asian cultures begin to disappear, and individual members tend not to maintain their ethnic identities. Family members communicate in English only and adopt a more individualistic and egalitarian orientation.

The Interracial Family

The rate of marriages between Asian Americans and members of other racial groups is steadily increasing. Some interracial families are successful in integrating both cultures, but many struggle with their biracial or multiracial identity. Common areas of conflict in interracial marriages include values, religious beliefs, communication styles, racism, childbearing issues, and in-law problems.

Most Asian countries have changed rapidly in the past three decades due to modernization, urbanization, industrialization, and, in recent years, improved communication and business efficiency resulting from technological advances worldwide. These changes are obvious in Japan, China and the so-called "Four Tigers"—Taiwan, Korea, Hong Kong, and Singapore. India has also recently blossomed into a major center for software development for many high-tech companies in the United States as well as a source of thousands of programmers who come to the United States to work on temporary H1 visas.

It is important to remember that Asian countries, as they evolve under the influence of these recent socioeconomic forces, may take on dramatically different characteristics that affect their people and family systems. Providers should be prepared for a family of farmers from a mountaintop in Laos to be very different in terms of family values, Westernization, formal education, and outlook from an urban family from Hong Kong or New Delhi in which the parents work for high-tech companies.

Strength, Resilience, and Community

It is also important to recognize the strengths and resilience of many API individuals, families, and communities. Although many immigrant and refugee families arrived in the United States under great socioeconomic and psychological stress, they also possessed personal, cultural, philosophical, and spiritual strengths. For instance, the Eastern philosophical approach to life teaches the importance of family obligations and loyalty, filial piety, and parental sacrifice for the future of the children. High parental expectations regarding educational achievement and a strong work ethic have resulted in many academic and business successes. The teaching of karma and compassion, and the strong focus on

family harmony and interpersonal relationships, have provided much-needed support during personal and family crises. Native Hawaiian and other Pacific Islander families have increasingly drawn upon cultural values and practices to promote resiliency, specifically emphasizing strategies that involve the family and community, spiritual diversity, and native sovereignty to build personal and community strength (McCubbin, Thompson, Thompson, & Fromer, 1995). The divorce rate for API couples is roughly half that of non-Hispanic Whites (U.S. Census Bureau, 2000c). Various immigrant groups have sustained cohesion and cultural identity strongly enough to establish thriving centers of culture, commerce, and population, such as the Chinatowns, Koreatowns, Japantowns, and Little Saigons evident in many U.S. urban areas. Strong civic organizations in these API ethnic communities provide important opportunities for social support, networking, advocacy for community needs, and development of cultural pride.

Strong community ties may affect utilization of mainstream mental health services because of the availability of natural support systems within the community. These natural support systems are an important strength, especially if they are effectively linked with larger mental health systems when the need arises for referral. Partnerships with community-based organizations are thus an important part of culturally competent mental health services and help to cultivate provider awareness of assets within API communities.

Barriers to Adequate Care and Concerns With Current Mental Health Service Systems

Major Barriers

Early studies in mental health settings demonstrated that Asian Americans were usually underrepresented as clients and had higher dropout rates and shorter stays than did Caucasian Americans (Sue & McKinney, 1975; Sue & Sue, 1974). More recently, according to *Mental Health: A Report of the Surgeon General* (1999), one national sample revealed that Asian Americans were only one-quarter as likely as Whites, and one-half as likely as African and Hispanic Americans, to have sought outpatient treatment for mental health concerns. Asian Americans are also less likely than Whites to be psychiatric inpatients. Yet several studies also found that Asian Americans exhibit more severe disturbances compared with non-Asians, suggesting that they are likely to endure psychiatric distress for a longer time before finally coming to the attention of the mental health system at the point of acute breakdown and crisis. Studies also show that Asian Americans are more likely to drop out after initial contact with mental health providers or to terminate prematurely (Uba, 1994).

There are a number of possible explanations for these low utilization and high dropout rates (See Panel on Mental Health Standards of Care for Asian and Pacific Islander Populations, 1998):

- Lack of services available in consumers' primary languages effectively prevents many individuals from seeking or receiving help.
- Existing services typically are not responsive to the needs of Asian Americans and Pacific Islanders. Western diagnostic criteria may overlook culturally specific symptom expression and culture-bound syndromes, for example.
- Services may be geographically inaccessible.
- Asian American and Pacific Islander clients may feel that their cultural viewpoints are not understood or valued and thus may be suspicious of non-Asian clinicians.
- There is a shortage of culturally competent personnel.
- Consumers lack awareness of the availability of local mental health services, or of the right to receive services.
- Consumers lack familiarity with U.S. community mental health systems, which are different from those of their countries of origin.

- Consumers lack financial resources. Many working-class Asian Americans do not have health insurance or other health benefits. Census data indicate, for example, that 21.1 percent of APIs are uninsured, compared with 11.9 percent of non-Hispanic Whites (U.S. Census Bureau, 1999).

- Consumers may have cultural inhibitions about seeking mental health services, including stigma, shame, and other cultural factors that influence symptom expression, concepts of illness, and help-seeking behaviors.

- Consumers may have different help-seeking patterns. Some traditional Asian Americans seek help from primary care physicians, community leaders, or indigenous or spiritual healers rather than mental health professionals.

It is essential that mental health administrators and planners address these barriers in order to make mental health services more accessible, available, and culturally appropriate for API clients.

Existing Models of Mental Health Service Delivery to the API Community

Most mental health services currently available to API persons fall into one of two major types:

Services Administered and Operated by Mainstream Organizations

In many geographic areas where API populations are small and relatively invisible, services are usually provided in public mental health settings by English-speaking, non-API providers with or without trained interpreters. In areas with large API populations, some mainstream organizations employ bilingual API personnel, and some have developed API-focused programs or teams (e.g., the Asian In-Patient Unit at San Francisco General Hospital). Some agencies have developed satellite clinics or mental health centers specifically focusing on API clients (e.g., Asian Pacific Family Center in Rosemead, California).

Services Administered and Operated by Nonprofit Organizations in the API Community

This model is found mainly on the East and West Coasts, and in some major cities with large API populations in other regions of the country. Services and programs are specifically designed to meet the needs of API populations and have bilingual, bicultural providers. Clients have easier access to ethnically similar mental health professionals. These nonprofit organizations are usually community

based, with API members on the board and management team (e.g., Asian Pacific Development Center in Denver and Richmond Area Multi-Services, Inc., in San Francisco). In some communities, mental health services are provided by community health centers (e.g., South Cove Community Health Center in Boston).

From the mid-1970s to 1985, with federal, state, and local government support, a number of mental health centers whose goal was to serve the API population were established in several major U.S. cities with large API populations. Evidence indicates that these ethnic-specific, community-based service organizations, which typically have bicultural and bilingual staff and culturally competent services and treatment, increased the utilization rates, length of stay in treatment, client satisfaction, and positive therapeutic outcomes for API consumers (Flaskerud, 1986; Flaskerud & Liu, 1991; Russell, Fujino, Sue, Cheung, & Snowden, 1996; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Zane, Enomoto, & Chun, 1994; Zane, Hatanaka, Park, & Akutsu, 1994). One study indicated that API clients who attended ethnicity-specific programs had a higher return rate and stayed in the treatment longer than those using mainstream services (Takeuchi, Sue, & Yeh, 1995). Another tested the hypothesis that therapist-client matches in ethnicity and language are beneficial to clients. Results indicted that for API clients whose primary language was not English, ethnic and language match was a predictor of increased duration and positive outcome of treatment (Sue et al., 1991).

In spite of the advantages of culturally competent services and ethnically matched providers, many API consumers are still being served by providers with little understanding of API cultures and communication styles. The number of mental health centers in API communities is limited, and these centers typically provide only outpatient and sometimes day treatment services. The remaining range of mental health services, including inpatient care, partial hospitalization, residential care (including board-and-care homes), emergency services, vocational training, dual- diagnosis treatment, and jail psychiatric services are still provided primarily by mainstream organizations in an uncoordinated and fragmented manner.

Special Issues With Managed Care Mental Health Systems

At the 1995 Asian American and Pacific Islander Mental Health Conference, convened by the Center for Mental Health Services (CMHS) with the participation of leaders and directors of API-focused mental health agencies, participants expressed a great deal of concern regarding the negative impact of managed care on cultural competency in mental health service delivery to API Americans. Prior to the July 1999 Asian American and Pacific Islander Mental Health Summit, the author of this report conducted a survey of API mental health directors on the impact of managed care on services and on barriers they experienced after the implementation of managed care in their communities. The following section summarizes their comments.

Problems With Access and Benefit Design

- Gatekeeping and service authorization for API consumers is usually performed by non-API staff. Many API consumers are excluded from services by language and cultural barriers.
- Some health benefit packages do not provide treatment for disorders that affect many API individuals, such as PTSD and other anxiety disorders.
- Many health maintenance organizations (HMOs) do not provide information regarding covered services and procedures for accessing and utilizing services in API consumers' primary language(s). Also, the conventional means of disseminating this information do not reach many API communities.
- Despite the capitated model, managed care organizations usually do not allocate money for prevention, outreach, and health promotion.

Services

- Many HMOs lack culturally competent services and programs to address the special needs of API members.
- Many HMO services are not located within Asian communities or in geographically accessible areas.
- Services are usually not accessible to API members, especially monolingual clients from recently emerging population groups.
- Indigenous healing practices are seldom viewed as an integral part of a system of care; complementary or traditional healers usually are not included as treatment plan providers.
- Services tend to be based on a short-term intervention model. The duration of services is often influenced by efforts to reduce costs rather than by clinical need.
- Treatment modalities usually focus on the individual and emphasize the medical model. Family therapy sessions often are not covered by HMOs, although API persons often value family involvement in treatment.
- Although it is clear that integrating primary health care, mental health, substance abuse, school-based, and other social services in a managed care plan increases the potential that API consumers will receive more comprehensive and accessible services, integration and

collaboration efforts are highly fragmented. Many areas lack cross-system alliances for integrated service delivery.

Provider Competency

- Few HMOs make a concerted effort to recruit and retain a representative percentage of API mental health professionals in their clinical workforces.
- Fee scales for preferred provider networks often are too low to attract culturally competent mental health API specialists to join.

Planning/Evaluation/Management

- Few API individuals are involved in HMO governance or hold leadership positions.
- Consumers and family members either are not included in planning and advocacy or their participation is viewed negatively by many managed care organizations.
- Outcome measures are based primarily on mainstream models.
- The inexperience of managed care agencies has led to fiscal mismanagement in some states. This has caused many API agencies to lose funding for needed services.
- Different states develop different cultural competency standards. Many private HMOs have no cultural competency plans in effect.

In summary, barriers to providing adequate care to Asian Americans and Pacific Islanders using current mental health systems include language barriers; lack of accessibility of culturally competent services; lack of familiarity with U.S. mental health systems; and a critical shortage of bilingual, bicultural API mental health professionals. In addition, cultural inhibitions such as stigma and shame about seeking mental health services exist. To address some of the major barriers and concerns, the following section describes national efforts to ensure a more culturally competent system of care for API communities and provides recommendations for culturally competent assessment and treatment strategies.

Moving Toward Culturally Competent Mental Health Systems

Ensuring a Culturally Competent Mental Health System of Care for API Communities

Several national activities and initiatives have been undertaken to promote a culturally competent system of mental health care for API communities. These include convening of national conferences on API mental health needs, development of recommended standards of care for the provision of behavioral health services to Asian and Pacific Islander Americans, development of new mental health programming for API populations in rural areas, and other national-level initiatives germane to API mental health needs. These are briefly discussed below.

National Conferences on Mental Health Needs of Asian and Pacific Islander Americans

In 1972 the National Institute of Mental Health sponsored a national conference in San Francisco to address mental health issues in the API community. That conference initiated a period of tremendous creativity in the areas of research, training, preventive services, and coordination of efforts. New resources entered the community, resulting in increased responsiveness to API mental health needs. Since the mid-1980s, however, many of the programs and structures created in the 1970s have declined or disappeared, although the API population has tripled. Thus the need for appropriate, culturally competent services has also increased. Enormous disparities exist between the API and mainstream communities in terms of availability of and access to high-quality mental health services. With the rapid transition to managed care, linguistic access and compliance with Title VI of the Civil Rights Act (which prohibits discrimination in programs or activities receiving federal assistance) have once again become a matter of concern for the API community.

Under the leadership of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) in 1979 and the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1995 and 1999, national conferences on API mental health were held to develop recommendations for improving mental health services. The 1995 conference focused on the effects of managed care; the 1999 summit addressed ethnic-specific services, cultural competence, and child and adolescent mental health. Participants submitted recommendations in each area to SAMHSA's Center for Mental Health Services (CMHS). These included, for example, recommendations that SAMHSA work to:

- create a grant program to improve API mental health services similar to the Community Action Grant program,
- increase community and provider awareness of API families and consumers,

- establish an API mental health resource development center,
- support implementation in state and community mental health settings of the cultural competence standards published by CMHS (2000),
- improve data collection methods and increase research on API mental health, and
- convene a national summit meeting focusing on child and adolescent mental health issues.

CMHS is developing a formal response to these recommendations. The National Asian American and Pacific Islander Mental Health Association (NAAPIMHA), formed in July 2000, will advocate for and coordinate new initiatives that may result from these efforts.

Development of Cultural Competence Standards

In 1996 the Western Interstate Commission for Higher Education (WICHE) Mental Health Program, with funding from CMHS and SAMHSA, formed a panel of API experts to review the literature and research related to API mental health needs and services. The 23-member API panel was co-chaired by Stanley Sue, Ph.D., and the author of this report. Following this literature review, panel members recommended standards for the provision of culturally competent managed mental health care services to API persons. In 1997 some of the API panel members met with members of panels representing three other underserved ethnic groups (African Americans, Latino Americans, and Native Americans) to reach a consensus about core cultural competence standards applicable to all four groups. The resulting document, *Cultural Competence Standards in Managed Mental Health Care Services: Four Underserved/Underrepresented Racial/Ethnic Groups*, was published in its final form in 2000 by CMHS.

National Effort to Address Mental Health Service Needs of API Persons in Rural Communities

During the past few decades, the number of API persons living in rural areas throughout the United States has increased significantly—by as much as 30 to 50 percent in many areas. The challenges of providing mental health services to API consumers in rural areas are many. Residents of rural areas often lack geographically accessible, appropriate mental health services. API language barriers and cultural differences compound this problem. Few bilingual, bicultural mental health professionals live and work in rural communities.

The Promoting Access to Health (PATH) program of the Association of Asian Pacific Community

Health Organizations (AAPCHO) originated as part of a cooperative agreement between the federal Office of Minority Health and AAPCHO in 1997 to address the health issues of emerging API communities in the Midwestern and Mountain states. An issue that arose repeatedly was the increasing need for—yet lack of—mental health and substance abuse services. In July 1999, AAPCHO and SAMHSA held a one-day conference to discuss strategies for providing mental health services to API persons. Conference participants made several recommendations to SAMHSA that paralleled those of the 1999 summit, and they also suggested increased funding for mental health services and active support for service integration.

In addition to these national activities, several other important initiatives provide unique opportunities to address the unmet health and mental health needs of API communities. Many in the API community hope that the June 1999 White House Conference on Mental Health, the Surgeon General's 1999 report on mental health, the Clinton administration's initiative to eliminate disparities in health care, and Executive Order 13125 on Increasing Participation of Asian Americans and Pacific Islanders in federal programs will lead to positive changes and increased resources to meet the mental health needs of API communities.

Executive Order 13125, which President Clinton signed on June 7, 1999, established the President's Advisory Commission on Asian Americans and Pacific Islanders and the White House Initiative on Asian Americans and Pacific Islanders. The President appointed a 15-member commission to act as his advisers in working toward three goals:

- Develop, monitor, and coordinate federal efforts to improve Asian American and Pacific Islander participation in government programs.
- Foster research and data collection for Asian American and Pacific Islander populations and subpopulations.
- Increase public- and private-sector and community involvement in improving the health and well-being of Asian Americans and Pacific Islanders.

Moving toward culturally competent mental health systems requires special efforts to redesign service systems and culturally competent clinical practices in working with individual consumers and their families. The following section presents assessment and treatment strategies for working with Asian American immigrant and refugee families.

Culturally Competent Assessment Guidelines

- Providing culturally competent mental health services requires that the client's culture be understood, accepted, and respected by the provider during all phases of the therapeutic

process. In order to provide effective mental health services to Asian American families, providers must be able to both conceptualize and intervene at multiple levels and in multiple systems. Providers also need to investigate the efficacy of traditional assessment methods and instruments.

- Many API consumers and family members may not comprehend the significance of sometimes lengthy and complex evaluation procedures. They may not be accustomed to detailed history-taking and may not understand the relationship between the questions and the presenting problems. Many are also very discreet about family secrets and problems, and they may not wish to offer information before trust is established.

- Many API persons are not accustomed to verbal expression of emotion to outsiders. This may be further complicated by linguistic barriers. Monolingual clients often have difficulties communicating with English-speaking providers through an interpreter, owing to linguistic, communication, and cultural differences.

- There is a need for assessment tools that have been translated and standardized in API languages and appropriately normed for clients of API backgrounds. For example, API persons may tend to avoid endorsement of the extremes on measurement scales such as Likert scales, rendering the results of this type of assessment instrument questionable.

- Providers working with API consumers may need to incorporate a more holistic way of thinking into clinical practice and assessment. The evaluation of API families should include information beyond traditional intake data. A model is presented below that accounts not only for the psychological and biological influences on an individual's or family's emotional health, but also for the cultural, social, political, family, community, and spiritual influences. Table 2 provides a summary of the types of information needed in each key area (Lee, 1989; 1996; 1997).

Table 2. Assessment Guidelines for Asian American Immigrant and Refugee Families

Area of Assessment	*Assessment Content*
Family's ethnocultural heritage	- Country of origin: paternal and maternal ancestry - Province/city/village of origin - Generations in the United States - Cultural identity of each family member
Family migration stress and relocation history	- Premigration experience (life before migration); relocation history - Type of community where the family lived - Socioeconomic status - Educational, health, and mental health systems in the home country - Traumatic events encountered - Migration experience (the escape/relocation process) - Decisions to leave: why, when, and who - Degree and type of hardships during escape - Stress induced by legal immigration process: uncertainty of sponsorship, duration of waiting
Degree of loss and traumatic experience	- Separation and losses of family members, relatives, experience, and friends - Financial and material losses - Loss of spiritual and cultural communities - Physical trauma - Psychological trauma
Postmigration experience and cultural shock	- Postmigration (life immediately after the arrival in the United States) - School adjustment - Job and financial worries - Changes in living environment and neighborhood - Significant changes in family composition and relationships - Learning and adjusting to Western values - Problems with housing, transportation, child care, and legal issues - Racism and minority status

Table 2. Assessment Guidelines for Asian American Immigrant and Refugee Families *continued*

Area of Assessment	*Assessment Content*
Acculturation level of each family	Individual family member acculturation rate depends on: - Years in host country - Age at time of migration - Exposure to Western culture - Professional affiliation - Contacts with American peers - English-speaking ability - Work or school environment
Work and financial stresses	- Unemployment - Underemployment/downward mobility - Long working hours - Language difficulty - Racism at the workplace - "Glass ceiling" issue
Family's place of residence	- Type of neighborhood - Availability of support system - Help available from community-based service agencies - Community stigma
Family dynamics	- Family membership/composition - Leadership - Decisionmaking - Role assignments - Communication patterns
Family problems	- Intergenerational conflicts - In-law conflicts - Marital difficulty - Role reversal - Addiction, substance abuse, and gambling

Table 2. Assessment Guidelines for Asian American Immigrant and Refugee Families *continued*

Area of Assessment	*Assessment Content*
Family strengths	- Functional coping strategies - Strong family bond - Support from the ethnic community and networks
Physical health and medication history	- Medical history of client and family members - Exposure to Western and herbal medicines - Consultation with physician and indigenous healers
Family's concept of presenting problem, help-seeking behavior, and treatment expectations	- Symptoms and problems as perceived by family - Causes of the problems as perceived by family - Relationship with traumatic events - Family help-seeking behavior - Treatment expectations

Culturally Competent Treatment Strategies

Because Asian Americans represent a broad spectrum of cultures, histories, and acculturation levels, providers need not only to expand the domain of their assessments but also to flexibly apply different treatment modalities in response to the needs of each individual and family.

Many forms of therapy are effective with Asian Americans. A survey of Asian American counselors found that somatic problems were often effectively treated with pharmacotherapy, adjustment problems with cognitive behavior methods, and intrapsychic problems (e.g., identity conflicts, relationship problems, low self-concept) with psychodynamic and related techniques emphasizing self-exploration (Matsushima & Tashima, 1982).

Authors of a review of the literature and research on Asian and Pacific Islander mental health arrived at several conclusions regarding recommended treatment modalities (Panel on Mental Health Standards of Care for Asian and Pacific Islander American Populations, 1998): Findings indicated that depression and PTSD can be successfully treated through psychotherapy and pharmacotherapy; culturally competent group therapy and clinical case management were found to be effective in working with Asian Americans; many authors recommended the use of family therapy whenever possible to accommodate Asian Americans' family-centered orientation; a family treatment model also may be more cost-effective due to the strong family orientation of most Asian American groups; and family therapy may also be useful for addressing the turmoil and stress resulting from structural realignments that often occur in recently immigrated families.

For a more detailed discussion of all types of treatment modalities, see *Working with Asian Americans: A Guide for Clinicians* (Lee, 1997). The following treatment strategies for working with immigrant Asian American families are presented as one of many models.

Form a social and cultural connection with the family during the first session. The most important process in working with Asian American families is "joining," that is, initiating therapeutic intervention by building a relationship with the family. Many Asian American clients are new to therapy and may need to be prepared and "coached." During the first session, the clinician should address the family in a polite and formal manner. Given Asian cultures' emphasis on interpersonal relationships, the family may expect the clinician to disclose a certain amount of personal information regarding his/her family, country of origin, and academic and professional background. Appropriate self-disclosure may facilitate positive cultural alliance and an increased level of trust and confidence. Asking nonthreatening personal questions can put the family at ease. It is also important to avoid direct confrontation, to demand greater emotional disclosure, or to discuss culturally taboo subjects such as sex or death.

Acknowledge the family's sense of shame. For many Asians, the public admission of mental health problems can bring intense shame and humiliation. The clinician may counter those emotions by

empathizing with family members and encouraging them to verbalize this feeling. It is important to assure them about confidentiality and anonymity. One helpful technique is to reframe their courage in seeking help as love and concern for the troubled family member. If appropriate, mobilizing the family's sense of obligation to receive help to achieve family harmony or for the sake of the children can be very effective.

Clarify the professional's role and client treatment expectations. Because diverse mental health disciplines (e.g., psychiatrists, psychologists, social workers) are not widely recognized in many Asian countries, Asian Americans may lack the information or exposure to understand the roles of clinicians. The provider's role needs to be clarified at the beginning of treatment. Since the role of a physician is more clearly understood and respected, Asian American clients may expect clinicians to act like physicians who prescribe medication. In addition, the clinician needs to explore the client's treatment expectations.

Establish expertise, power, credibility, and authority. Many Asian clients come to their first session believing that the clinician is an authority who can tell them what is wrong and how to solve their problems. It is helpful for the clinician to establish credibility right away to ensure that the client will return. An air of confidence, empathic understanding, maturity, and professionalism are all-important ingredients.

Define the problem. A problem-focused family therapy approach with Asian American families appears to be very effective. The clinician should focus on the immediate crisis or problem that brought the family to the agency. In most instances, family members ask for professional help because of the difficulties they encounter with one particular family member (the identified patient). Family members may either be unaware of their role in contributing to the problem or unwilling to discuss those issues openly in front of others, particularly the children. For many families, working on the parent-child issue at the beginning is safer than working on marital problems that may exist.

Apply a family psychoeducational approach. Education is highly valued in Asian cultures. The psychoeducational approach based on social learning principles may be compatible with Asian values and beliefs. Such interventions focus on four major areas: (1) education about the illness or problem, for which educational materials in the patient's primary language are especially helpful; (2) communication training; (3) problem-solving training; and (4) behavior management strategies (McGill & Lee, 1986).

Build alliances with family members who have power. An accurate assessment of the power structure of the family is essential. Generally speaking, there are two types of power in the API family system: "role prescribed power" (usually given to the grandfather, father, eldest son, or the sponsor) and "psychological power" (usually maintained by the grandmother or the mother). Treatment will not be effective without permission of the leader(s). Clinicians should acknowledge and respect their power

in decisionmaking, avoid competition, and build a therapeutic alliance using all possible means.

Employ reframing techniques. Using the technique of reframing can help to build rapport with family members who have power. For example, the clinician can reframe the mother's overprotectiveness as "loving too much" and reframe the father's excessive working hours as "sacrificing for the economic well-being of the family."

Assume multiple helping roles. Flexibility and a willingness to assume multiple helping roles can enhance the therapeutic relationship, especially in working with multiproblem families. In addition to being the counselor, the clinician should be comfortable functioning as a teacher, advocate, and interpreter. Acting as a "cultural mediator" or using a family intermediary can be an effective tool in dealing with family conflicts. Show caring by "doing" and "being there" when the family needs help.

Restructure the social support system. Asian American families usually consist of closely knit extended families and support systems. However, many families and individuals isolate themselves when they encounter problems. As soon as possible, the clinician should help them to establish or reestablish a social support network that enables the family or the individual to form friendships, vent frustrations, and learn social and problem-solving skills.

Integrate Eastern and Western health approaches. Clinicians should take advantage of the holistic model of health in Eastern cultures and integrate its elements with the best Western medical and psychological practices. For example, in the treatment of a Chinese American consumer with depression, it can be helpful to provide education on the Western biological and psychological perspectives of the illness. It may also be important to explore Eastern approaches to treatment, such as the use of Chinese herbal medicine, acupuncture, qi gong, or yoga. Indeed, it may be particularly useful to point out to consumers where these frameworks intersect, such as a mutual concern with both biological causes and energy depletion in the understanding and treatment of depression.

Mobilize the family's cultural strengths. One of the functions of therapy is to mobilize the family's cultural strengths. Strengths in API families may include support from the extended family, a strong sense of obligation and family loyalty, parental sacrifice for the children's future, filial piety, strong focus on educational achievement and the work ethic, and support from the ethnic community. In many circumstances, especially when family members are coping with death, loss, or unpredictable changes, discussions of religious stories or philosophical teachings from Asian cultures can be very therapeutic.

Employ the concept of empowerment as a treatment goal. Empowerment here refers to the process whereby the clinician mobilizes the family's ability to interact successfully with external systems. This is particularly important in working with immigrant women who have been victimized by years of sexism, loss of power due to language barriers, role reversal, and racism in the new country.

Understand the family's communication style. In addition to determining API consumers' primary language and dialect, providers must understand a family's communication style. Asian Americans have traditionally been taught to employ indirect styles of communication and to avoid direct confrontations. Negative emotions such as anger, grief, and depression may be expressed indirectly. Even positive feelings such as love are frequently not expressed in an open manner. The clinician may be expected to read between the lines in order to grasp the major issue. The family may also, on the other hand, perceive the clinician as being too blunt, pushy, or insensitive.

Applicability to Pacific Islanders

These treatment strategies described as appropriate for Asian Americans also have relevance for Pacific Islanders. Strategies with special applicability include forming social and cultural connections between provider and family, integrating Eastern (or Pacific) and Western approaches, mobilizing the family's strengths, and employing the concept of empowerment. Successful establishment of a provider-family relationship for many Pacific Islanders requires that providers exhibit knowledge of, and sensitivity to, native history and circumstances. For example, recognizing the political history and affiliation of the United States to Pacific islands may facilitate an understanding of cultural conflict for Pacific Islanders in the United States and in island homelands. There is mixed literature on Native Hawaiians' preferences for indigenous or Western mental health treatments, with early research indicating a preference for indigenous approaches (Higginbotham, 1987) and more recent and comprehensive research indicating a preference for conventional medical practices (Andrade, et al., 1994). Interestingly, the latter study also showed that Native Hawaiian adolescents identified teachers and school counselors as the best source of help for mental health problems.

Providers who are competent in, and can flexibly employ, a range of both native and Western treatment interventions and who can collaborate with teachers/counselors may maximize their efforts at helping. Another way to enhance services is to mobilize the family's strengths in areas such as extended familial support and community networking. For example, in Hawaii the Department of Human Services utilizes an intervention called `Ohana (Family) Conferencing that brings together members of the extended family as well as individuals who are part of their neighborhood support system to collectively resolve issues of the children and family (Susan Chandler, personal communication, May 10, 2001). Focusing and mobilizing family strengths as part of an intervention contributes to empowerment because the family and community become active participants in the process of change (Browne & Mills, 2001). This is a key concept in work with Native Hawaiians, Samoans, and Chamorros and reflects the importance of families and communities taking responsibility for the direction of mental health services. Finally, the use of such strategies will be enhanced if providers continually engage in self-awareness activities that examine their own attitudes toward racism, oppression, cultural diversity, and identity (Mokuau, 1991).

In summary, providing culturally competent clinical services to Asian and Pacific Islander Americans,

especially immigrants and refugees, includes applying an understanding of cultural and sociopolitical factors in the development of both assessment guidelines and treatment strategies. A practical guide based on a holistic model is offered. Ensuring a culturally competent mental health system of care also requires multilevel interventions, such as planning and administrative leadership on the federal, state, and local fronts and advocacy and effective organization by API communities. Recent national efforts have brought opportunities to address barriers and concerns in mental health care delivery to the API population. The following section offers some recommendations for state mental health planners and administrators to help guide culturally competent systems change.

Recommendations for Mental Health Systems Change

Overcoming cultural, linguistic, socioeconomic, and geographic barriers to the provision of mental health services is not an easy task. Disparities in the availability of and access to high-quality mental health services must be addressed at every level—federal, state, county, city, and community. Recently, the recommendations of the 1999 National API Mental Health Summit and several federal initiatives have generated renewed enthusiasm among the API mental health communities. However, mental health services for Asian and Pacific Islander Americans can improve only with the support and partnership of the states. The following recommendations are provided for state mental health authorities:

Needs Assessment and Survey of API Populations

Conduct a statewide assessment of API populations, gathering data broken down by subgroups within the Asian and Pacific Islander populations; identify the cultural and linguistic backgrounds within each API community relevant to mental health and well-being. Such a population assessment is critical in designing and planning appropriate and effective mental health services and is particularly crucial in states with large or rapidly changing API populations. The 2000 Census provides a wealth of information on API demographics. Needs assessment tools have been developed and implemented in many API communities—such as the health needs assessment used with the San Francisco Chinese community (Jang, Lee, & Woo, 1998). For states with significant numbers of API populations, a more comprehensive API prevalence and service survey may be necessary to determine rates of mental disorders and patterns of mental health service utilization.

Cultural Competency Plan for API Populations

Develop and implement a cultural competency plan. This begins with a thorough and impartial ongoing organizational self-assessment. Organizational assessment can be conducted by minority consultants who are experts in cultural competency. Identify strengths and gaps in current services. Use the results of the needs and organizational assessments to design a specific cultural competency plan. Such a plan should include specific goals, policies, and procedures; adequate resource allocation; and designation of staff responsible for plan implementation. The cultural competency standards recently published by CMHS can be used as a guide.

Service Delivery Models

Develop new and/or support existing culturally competent mental health services to the API community. The following examples of such service models are based on ideas generated at the SAMHSA-

sponsored national conferences on API mental health in 1995 and 1999 and on the

publication *Cultural Competence Standards in Managed Mental Health Care Services* (CMHS, 2000):

- Integrate mental health services with primary health care. API persons are more likely to contact a physician than a mental health professional when they need help.
- Provide mental health services in natural settings (e.g., church/temples, schools, community centers). This reduces stigma associated with mental illness and increases service accessibility.
- Develop special programs or clinics to address problems that frequently affect API communities—such as a refugee trauma clinic or a problem-gambling treatment program.
- Use community-based family therapy interventions whenever possible.
- Incorporate Eastern treatment modalities into assessment and treatment. Advocate for insurance reimbursements and Medicare/Medicaid funding for complementary and alternative medicine practices, such as acupuncture.
- Develop culturally competent vocational training and job placement services, because work is highly valued by many API consumers and families.
- Partner with other state agencies, such as departments of education and rehabilitation, to create comprehensive, integrated service models.
- Allocate sufficient funding for prevention, early intervention, and outreach programs. Arrange for these programs to be developed and conducted in partnership with API community-based, non-mental health agencies.
- Develop culturally and linguistically appropriate written mental health education materials for API consumers and families. (This requires using the needs assessment data regarding population and language group.)

Recruit API Professionals for Mental Health Leadership Positions

Improve API representation on state mental health planning boards; among state and county mental health and medical directors; on key state and national committees; in state legislatures and budget offices; and in national, state, and local advocacy organizations. Hire senior API managers who have

a strong interest and expertise in cultural competence and can provide leadership to develop and implement such plans for the organization.

Community Partnership

Empower API consumers, family members, and community-based organizations to lead the mental health agenda. Ensure that there is fair and equitable API representation on policy, budget, and program planning boards and committees in order to appropriately address API issues and concerns. Establish strong working relationships with local, state, and national API organizations. Identify key API leaders who can provide advice and consultation on these efforts.

State Legislative Initiatives

Address mental health disparities by state legislation. For example, legislation has been proposed in California that would require the state Department of Mental Health, Department of Finance, and Office of the Legislative Analyst to form a work group to study options for restructuring mental health funding and services.

Human Resources Development

Provide leadership in the creation of a human resources development plan and strategy to address the extreme shortage of bilingual, bicultural API professionals in public mental health settings.

Training and Technical Assistance

Provide cultural competency training to agency managers and service providers. Organize cultural competency conferences at various locations on a regular basis. Assess the training needs of different county and city mental health systems, and provide technical assistance as indicated. Employ API consultants who can provide various types of training. Encourage educational institutions to modify education and training program eligibility requirements to create opportunities for students from API ethnic communities that are underserved and underrepresented.

Research

Advocate for increased funding for research to expand the knowledge base concerning the clinical and cost effectiveness of culturally competent mental health services. Special attention should be paid to outcomes research so that successful models may be replicated.

Monitoring and Accountability

Provide close monitoring of state-funded contractors to ensure culturally competent care for API consumers and family members. Contractors should demonstrate the following:

- Adequate language accessibility to all API groups and compliance with federal and state regulations.
- Development and implementation of an annual cultural competence plan with specific objectives and outcome measures.
- Improvement of data collection including data on subgroups within the API community.
- Provision of funding and resources to address service disparities that affect the API community.

Conclusion

This report describes the unique and diverse cultural characteristics, mental health needs, and problems of Asian and Pacific Islander Americans. In addition, the report identifies major cultural, linguistic, and socioeconomic barriers to mental health service access and utilization. A practical guideline in assessing and treating API families based on a holistic model is offered. Providers may try to incorporate this model into their clinical interventions with the goal of overcoming cultural barriers and achieving better treatment outcomes.

Ensuring a culturally competent mental health system of care for API persons also requires systems interventions on the federal, state, county, and local levels. Recent publications such as the U.S. Surgeon General's 1999 report on mental health and the *Cultural Competency Standards in Managed Mental Health Care Services*, as well as the National API Mental Health Summit, have generated much positive energy and renewed vigor in API communities. However, services to API persons will not improve without resources and support from states. The report offers recommendations that can serve as a guideline for state mental health planners and administrators to address issues of disparities in the availability and accessibility of culturally competent mental health services for API communities.

As the racial/ethnic group with the highest rate of population growth in the United States during the past decade, the API community is in rapid transition and is very diverse. With the present political and economic trends in the United States and Asia, this population is expected to continue to change in both size and complexity. Mental health planners need to keep abreast of these changes and be flexible in the design of culturally and linguistically appropriate services to this underserved population.

In the final section of this report, we offer examples of mental health programs that attempt to provide state-of-the-art services to API consumers, with some services targeted to specific subpopulations. Services are offered in many languages and modalities. These programs were chosen to represent efforts occurring in different geographical regions and because they meet several of the cultural competence criteria outlined in the CMHS report on cultural competency standards (CMHS, 2000).

Model Program:
Richmond Area Multi-Services, Inc. (RAMS)
San Francisco, California

Program Overview

Richmond Area Multi-Services, Inc. (RAMS) is a community-based mental health agency located in the Richmond District of San Francisco. Founded in 1974 by the Richmond Asian Caucus, RAMS is committed to providing community-based, culturally competent, and consumer-guided services that meet the mental health, social, and educational needs of the local community. RAMS' target populations include residents of the Richmond District and the greater Asian American communities in San Francisco. Many RAMS consumers are new immigrants and refugees who are in need of bilingual, bicultural mental health services. As the only nonprofit mental health agency with an API focus under contract with the city and county of San Francisco, RAMS has the unique opportunity and challenge to meet the mental health needs of the Asian Americans who constitute more than 36 percent of the city's population.

Clinical Programs

RAMS offers a variety of clinical programs to meet the specific needs of the community:

Adult Outpatient Services

The Adult Outpatient Program provides counseling; case management; individual, group, and family therapy; psychological testing; psychiatric evaluation; and medication support services to adults, couples, and their families. Special ethnic teams work with consumers from different API subgroups, including, but not limited to, Chinese, Japanese, Korean, and Vietnamese.

Adult Day Treatment Services

The adult day treatment program offers a partial-day structured program of group therapy, psychoeducation, prevocational counseling, English-language courses, medication support services, and training on cultural adaptation for refugees and immigrants who suffer from acute posttraumatic stress disorders and/or major depressive illnesses.

Children and Youth Services

RAMS provides a wide range of services for children, youth, and families. Services are provided at the clinic and at more than 40 community-based sites. RAMS' outpatient child mental health clinic offers psychological assessments, individual play therapy, family therapy, group therapy, psychiatric

medical evaluation, case management, consultation at school sites, "wrap-around" services to severely disturbed children at risk for out-of-home placement, and an after-school outreach program for gay/lesbian and questioning youth.

Partial Hospitalization Program

This program is a partnership between RAMS and the Department of Psychiatry at San Francisco General Hospital, which provides high-quality, cost-effective outpatient treatment to persons with serious and persistent mental illness.

Residential Care Home

This program provides 24-hour Asian-focused residential care for mentally ill consumers recently discharged from hospitals and other treatment centers.

Vocational Training

The "Hire-Ability" program provides culturally sensitive vocational evaluation, job preparation, and job placement services to individuals experiencing emotional difficulties, enabling them to get jobs and live independently in the community.

Problem Gambling Project

The Problem Gambling Project provides assessment, counseling, support groups, outreach, and educational services for problem gamblers and their family members in the Chinese and other Asian communities.

Fee-for-Service Programs

RAMS provides several fee-for-service programs to uninsured self-pay clients and contracts with HMOs to provide bilingual, bicultural counseling to their clients and employees.

Training

RAMS is committed to the training and development of culturally competent mental health professionals with expertise in working with Asian Americans and other minority groups. The training program includes two major components: the RAMS internship program, which provides clinical training to undergraduate and graduate students, and the National Asian American Psychology Training Center, a training program accredited by the American Psychological Association (APA) that started in 1979.

Research

RAMS is committed to research activities, with an emphasis on cross-cultural mental health issues. In addition to providing technical assistance to conduct research projects by its own staff and interns, RAMS has collaborated with other research institutions and universities.

Culturally Competent Initiatives or Strategies

RAMS has played a key role in defining and implementing culturally competent mental health services in San Francisco. The organization's staff believes that recovery and rehabilitation are more likely to occur where the mental health systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers and their families and communities. RAMS implements its commitment to cultural competence through many activities and initiatives:

Culturally Competent Leadership

The RAMS Board of Directors reflects the diversity of the community served. It includes consumers, professionals, and leaders from different Asian communities. There are several Advisory Committees for specific cultural groups, and the RAMS management team is also culturally diverse.

Culturally Competent Staff

The RAMS staff consists of a multidisciplinary team of mental health professionals: psychiatrists, psychologists, psychiatric social workers, marriage and family counselors, and mental health workers. Many are immigrants or refugees themselves and have expertise in specific areas such as cross-cultural counseling, child and adolescent mental health, elderly care, refugee trauma, and family therapy.

Treatment in Client's Primary Language

RAMS' staff reflects the multicultural, multilingual diversity of its community. Services are available in Russian and more than a dozen Asian languages (including Burmese, Cambodian, Cantonese, Hindi, Japanese, Korean, Mandarin, Tagalog, Taiwanese, Thai, Toishanese, and Vietnamese). Interpreters are available as needed.

Support for Consumer Choice and Empowerment

RAMS has pioneered the hiring of consumer consultants and community consultants for a wide array of roles from direct service provision to community advocacy. To help support consumer choice and empowerment, consumers have also been involved in the development of several booklets such as *How to Be a Smart Consumer in Managed Care* and *Consumer Satisfaction Report Card*. These booklets are available in five Asian languages—Cambodian, Chinese, Korean, Tagalog, and Vietnamese.

Community-Based, Accessible, and Culturally Appropriate Services

RAMS provides a community-based system of care that includes a full continuum of services. The focus is on treating the consumer in the least restrictive setting (e.g., outpatient, residential care, vocational training program) and investing in early intervention and prevention efforts (e.g., consultation programs for 0 to 5-year-olds in preschool and community-building efforts). Services and facilities are made geographically accessible by providing services in more than 40 sites including schools, childcare centers, youth centers, community centers for refugees, and other social service agencies. RAMS also offers evening and Saturday clinic hours. To respect the cultural beliefs of many Asian immigrants and refugees, holistic approaches to assessment and treatment are encouraged and highly valued.

Leadership in the Training and Development of Culturally Competent Mental Health Professionals

RAMS offers valuable clinical training for both undergraduate and graduate students in the fields of psychology, social work, nursing, medicine, psychiatry, counseling, and other mental health disciplines. RAMS National Asian American Psychology Training Center (NAAPTC) provides training for APA-approved, full-time pre- and postdoctoral psychology internships. Funded in the past by the National Institute of Mental Health, NAAPTC is the first training program in the United States to focus on the development of psychologists with expertise in working with API populations.

Collaborative Efforts

RAMS is committed to building partnerships with other service organizations. This goal is achieved through three major activities:

- Establishing collaborative agreements with other service projects to provide clinical, outreach, and preventive services. For example, children and youth programs offer services at 30 different program service sites. The Bridge To Wellness partial hospitalization program is a joint collaboration with San Francisco General Hospital.

- Establishing a community organization component to build community coalitions. RAMS invests in community building by serving as one of seven host agencies for Neighborhoods in Transition: A Multi-Cultural Partnership and the Richmond Neighborhood Coalition. Working in collaboration with other neighborhoods, RAMS community organizers mobilize schools, police, community centers, service providers, faith-based organizations, business leaders, parents, and youth to enhance and improve the quality of life of local neighborhoods.

- Participating in other community coalitions: RAMS is an active member of the Chinese Health Coalition, a consortium of more than 35 agencies serving the Asian community in San Francisco. RAMS' executive director, Evelyn Lee, has served as coalition president for the past six years and also serves as vice president of the San Francisco Mental Health Contractors Association.

Funding

Major funding for RAMS is provided by Community Mental Health Services, Department of Public Health of the City and County of San Francisco. Other funding sources include state and federal grants and fee-for-service programs.

Evaluation Efforts and Results

RAMS is committed to improving the quality of its services and to enhancing desired outcomes of service delivery. The following evaluation efforts are used to assess services:

- *Annual Program Reviews.* As part of CMHS' monitoring efforts, evaluations are conducted once a year by an independent evaluation team. Program evaluation includes two major areas: program performance and program compliance. During the past three years, RAMS' Outpatient Clinic received the highest possible rating in all areas.

- *Consumer Satisfaction Surveys and Outcome Studies.* RAMS hired a group of consumer outcome consultants and community consultants from five Asian cultural groups to design a Consumer Report Card to be available in five languages. A consumer satisfaction survey of RAMS' Outpatient Clinic yielded a rating of 3.63 (out of 4) in FY 98-99 and 3.59 in FY 97-98. Consumer satisfaction surveys are conducted on a monthly basis at the Partial Hospitalization Program. In 1999, 90 percent of clients reported that they were either "satisfied" or "very satisfied" with the services they received.

- *Accreditation Visits.* A Joint Commission on Accreditation of Health Care Organizations (JCAHCO) site visit was conducted at RAMS' partial hospitalization program last year. The program received an outstanding score (99 out of 100 compliant points). RAMS' National Asian American Psychology Training Center also receives regular accreditation visits and has been accredited continuously since 1979.

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Model Program:
The Asian Pacific Development Center (APDC)
Denver, Colorado

Program Overview

The Asian Pacific Development Center (APDC) is a not-for-profit, 501(c)(3) community-based organization governed by a board of directors that reflects the diverse Asian ethnic and language communities. APDC is the only Asian/Pacific Islander-specific multiservice agency in Colorado and provides consultation, education, and services to the entire state. The targeted populations include people who are Cambodian, Chinese, Hmong, Japanese, Korean, Laotian, Thai, and Vietnamese. The majority of APDC clinicians are bilingual and sensitive to cross-cultural issues and the necessity for culturally competent services.

Clinical Programs

APDC was established in 1980 with funds from the U.S. Office of Refugee Resettlement. The initial focus of the agency was to provide mental health services to Southeast Asian refugees resettling in the United States. Recognizing the necessity to provide a broad array of programs to meet the multifaceted needs of the various Asian American and Pacific Islander communities, APDC has since developed numerous non-mental health services. APDC serves as an umbrella organization that houses an array programs. The Asian/Pacific Center for Human Development (A/PCHD) acts as the behavioral health care arm of the agency, offering a wide range of mental health and victim assistance services. APDC provides services to children, youth, adults, and senior citizens.

Youth programs cover a broad spectrum of services, from intensive individual counseling to programs designed to support high-achieving youth with the potential to become community leaders. The agency recognizes that troubled youth needing intensive services may also be the same youth who will participate in the leadership-building programs if given the proper support. APDC has received numerous federal grants to design and implement programs for API youth at risk for involvement in substance use, violence and gangs. The agency was one of 15 sites selected nationally by the U.S. Department of Health and Human Services' Center for Substance Abuse Prevention (CSAP) Project Youth Connect to participate in a cross-site evaluation designed to assess the effectiveness of mentoring for high-risk youth. Other activities include the Peer Leadership Training program; a drop-in center; a one-on-one mentoring program; and Asian Students for Corporate Experience and Network Development (ASCEND), a program designed to provide challenging professional opportunities for Asian and Pacific Islander youth to help prepare them for positions of leadership and success.

The Asian/Pacific Center for Human Development is a community-initiated community mental health clinic licensed by the Colorado Department of Public Health and Environment. A/PCHD is committed to providing culturally competent, community-based, and consumer-driven mental health services in a number of different Asian languages and dialects. A/PCHD acts as a bridge between the various API communities and the mental health system. Culturally competent mental health assessment, psychotherapy, counseling, medication treatment, and support services are hallmarks of A/PCHD. The center also provides senior outreach programs, victim assistance programs, domestic violence counseling, and substance abuse education and therapy services.

Culturally Competent Initiatives or Strategies

APDC has been providing services to Asian and Pacific Islander individuals in a culturally competent manner for more than 20 years and has received recognition in the publication *Towards a Culturally Competent System of Care, Vol. II: Programs Which Utilize Culturally Competent Principles* (Isaacs & Benjamin, 1991).

Cultural competency goes beyond the mere use of an interpreter and involves recognizing and valuing different worldviews; different social and cultural practices; and different perceptions of what constitutes health, pathology, and appropriate intervention strategies. It requires a willingness to modify the standard Western way of doing things and to value alternative approaches leading to the desired outcome. This includes respect for the use of traditional Asian folk healing practices and medicine. Culturally competent care includes cognizance of the dynamics of multicultural interactions and entails both an organizational and individual capacity for cultural self-assessment. APDC staff provides consultation and education on working with AA/PI clients. This includes understanding differences in cultural values such as beliefs regarding spirits, beliefs about mental health, child-rearing practices, communication styles, expectations of the role of family and extended family members, and expectations regarding the appropriate use of interpreters.

Collaborative Efforts

APDC works collaboratively with departments of social services, the courts, hospitals, schools, businesses, and other mental health agencies to improve the quality of services to API clients. These efforts include developing strategies to provide wraparound services, working with parents, providing case management, assisting with citizenship status concerns, providing interpreting services, and assisting with legal and medical concerns. When collaborating with other agencies, APDC stresses the fact that culturally competent services involve more than translation. They include developing an accurate understanding of the role of culture while exploring alternative ways of perceiving the clients' situations and coming up with alternative intervention strategies.

Funding

APDC receives grants from various funding agencies at the local, state, and federal levels. A/PCHD also subcontracts (both subcapitated and provider contracts) with different mental health assessment and service agencies to receive Medicaid reimbursement. Other sources of funding include contracts with social services, county judicial districts and juvenile courts, and fees for services. Fund-raising activities such as an annual Asian New Year's Dinner also generate financial support. APDC has implemented a successful conference for adopted Asian children, which generates revenue for services.

Evaluation Efforts and Results

The child/adolescent after-school programs have been evaluated and shown to be highly effective in improving participants' attitudes toward school, improving self-esteem, and establishing healthy relationships with an appropriate adult role model. Evaluation and data collection continue to be an ongoing challenge for all API community-based agencies. A limited number of evaluation instruments have been normed for API populations, thus making outcomes assessment based on quantitative analysis difficult. Qualitative outcomes, however, have shown programs to be effective.

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Model Program:
Hale Na`au Pono (House of Inner Balance)
Wai`anae, Hawaii

Program Overview

Hale Na`au Pono (HNP) is a community mental health center on the Wai`anae Coast on the island of Oahu in Hawaii. Established as a private, nonprofit corporation in 1987 after spinning off from the Hawaii Department of Health, HNP was founded on the principle that communities should direct their own mental health services. It provides a continuum of mental health care for adults and adolescents with an emphasis on socially and culturally sensitive services. HNP serves a culturally diverse community comprising predominantly Native Hawaiians, but also including members of other groups such as Caucasians, Filipinos, Samoans, Japanese, Chinese, Koreans, Puerto Ricans, and Vietnamese. The program was recognized for its integration of Pacific (particularly Hawaiian), Asian, and Western cultural traditions into mental health services with the 1999 Managed Behavioral Healthcare Leadership Award from the National Managed Healthcare Congress.

Clinical Programs

The clinical programs of HNP are uniquely influenced by cultural practices that emphasize the relationships of the individual, the family, the community, and the natural environment in the context of a broader spiritual realm. In Native Hawaiian culture, the focus is on this system of relationships rather than on the individual.

Adult Program

HNP provides three distinct approaches for the care of adults. The first approach, Outpatient Services, focuses on case management with a Care Team that consists of the therapist or care coordinator, a psychiatrist, a nurse, other mental health members, and the consumer. The treatment method for individual behavioral health needs integrates pharmacology with family life, education, and cultural appreciation. The second approach, Mobile Community Treatment (MCT), also utilizes case management with a Care Team dedicated to helping adults stabilize and live and work in their communities. A unique feature of MCT is the delivery of services in the home or natural environment sites such as the ocean and mountains. Emphasis is on the environment as a milieu for healing. The third approach, Hui Hana Pono—A Clubhouse, focuses on work as the central ingredient in the rehabilitation of adults with psychiatric illnesses. Clients' abilities to contribute to the daily operations of the clubhouse as well as to community employment are strengthened with the building of self-esteem and meaningful relationships. Group classes in activities that facilitate interpersonal interactions, such as the Hawaiian hula (dance) and chanting, support the clubhouse approach.

Child and Family Programs

Programs for children, adolescents, and their families include outpatient services, after-school day support, adolescent day treatment, and therapeutic foster homes. Outpatient services focus on case management as well as clinical therapy. One specific area of case management is youth substance abuse prevention and treatment. A manager coordinates an interdisciplinary team providing multiple innovative services. These services emphasize a balance of the person/family with the environment through a focus on subsistence farming, nutrition, and food production. Clinical therapy for individuals, groups, and families is also available to assist participants when needed. A Native Hawaiian form of family and group work—ho`oponopono—is often used to resolve interpersonal issues that divide families and other relationships. This approach embraces Hawaiian values and process in maintaining and restoring family and group relationships, and emphasizes the infusion of spirituality throughout the process.

The after-school day support program is prevention focused and utilizes collaborative partnerships with school personnel and other professionals to provide recreational activities in the areas of prosocial skills/behaviors and anger management.

The adolescent day treatment program is a transitional school program that combines treatment and education with the goal of returning youths to their home schools.

Therapeutic foster homes provide youths with a positive home environment and maintain children and adolescents in community facilities rather than in out-of-community or out-of-state facilities so that reunification with biological families can be expedited.

Culturally Competent Initiatives or Strategies

The infusion of cultural values and practices evident in the clinical programs of HNP is consistent with its philosophy, mission, and administrative governance and the geographical accessibility of facilities. The philosophy of HNP is that a system of care that draws from the strengths of its diverse cultural community is in the best position to prosper and contribute to its constituents' well-being. This philosophy is evident in the mission statement: "to provide without prejudice, within a cultural and social context, a continuum of care which includes prevention and emergency intervention for adults, children and adolescents with mental illnesses, emotional disturbances and substance abuse problems; to empower them to live in the community, pursuing life goals of their own choosing."

Administrative governance by HNP is culturally unique. All members of the Board of Directors are from the Wai`anae community and represent diverse professional backgrounds, including international human rights work, community development, nursing, speech pathology, theology, teaching, law, and law enforcement. They also reflect the multicultural diversity of the community, including Native

Hawaiian, Filipino, Caucasian, Japanese, and Chinese cultures. The staff of HNP are also of diverse cultural origins, and they recognize the important ramifications of culture in mental health service delivery. The staff consists of interdisciplinary professionals from the fields of psychiatry, psychology, nursing, and social work and other mental health workers with expertise in subsistence farming, nutrition, and cultural activities. HNP actively recruits staff members who have gone through the graduate internship training programs (e.g., social work) sponsored jointly by HNP and the University of Hawaii. HNP also actively recruits consumers of services to work within the agency, either as board or staff members.

The multisite facilities of HNP are easily accessible to the community. Most staff and services are based at two primary sites. The program also operates a school, a clubhouse, and two residential facilities for youth and adults. In addition, many program activities are provided in the home or in natural environments such as the mountains or ocean.

Collaborative Efforts

In keeping with its community-based philosophy, HNP is committed to collaborative partnerships with other networks and organizations. HNP works with departments of health, social services, education, and criminal justice to address the needs of this community. The organization also maintains an inclusive approach by inviting community members to sit on the advisory councils of the various clinical programs and by enabling HNP board and staff members reciprocally to sit on the advisory councils of other community organizations such as the American Cancer Society, Domestic Awareness Coalition, and the Special Olympics. HNP regularly provides education on mental health issues in the public schools, publishes and distributes a weekly newsletter on mental health, and participates in a weekly radio program that increases awareness of mental health issues.

HNP's commitment to community empowerment is also reflected in the organization's efforts to support other ancillary mental health groups. It has provided administrative support and free use of office space to other community support programs addressing legal services for children, charter schools, and alternative community development models (e.g., aqua-culture fish tanks).

Funding

HNP services are funded by the Hawaii Department of Health through contracts and grants, and by private insurance reimbursements. Originally relying entirely on state funding, HNP has aggressively pursued third-party billing. Today revenues received from billings exceed state support and have fostered, through financial accountability, the impetus to continuously refine and expand services.

Evaluation Efforts and Results

HNP is committed to excellence in the provision of mental health services. It is the first mental health center in Hawaii to receive national accreditation by the Commission on Accreditation of Rehabilitation Facilities for mental health case management and outpatient services. It has been accredited continuously since 1995. There are multiple indicators of effectiveness for each of the clinical programs, including percentages of consumers achieving treatment objectives, consumers' improvement in Global Assessment of Functioning (DSM-IV) scores, improvement in youth school attendance and performance, and general satisfaction ratings from individuals and families.

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Suggested Readings on Cultural Competency

***Cultural Diversity Series* (current volumes):**

McCarn, S. R. (1999). *Cultural diversity series: Meeting the mental health needs of gay, lesbian, bisexual and transgender persons.* Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

National Technical Assistance Center for State Mental Health Planning. (1998). *Cultural diversity series: Meeting the mental health needs of African Americans.* Alexandria, VA: Author.

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National Technical Assistance Center for State Mental Health Planning. (2001). *Cultural diversity series: Creating culturally competent mental health systems for Latinos: perspectives from an expert panel.* Alexandria, VA: Author.

***Cultural Diversity Series* (volumes in development):**

Meeting the mental health needs of American Indians and Alaskan Natives.

Other Suggested Readings:

American Counseling Association. *Journal of Multicultural Counseling and Development*.

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Organizational Resources

Action Council for Cross-Cultural Mental Health and Human Services, Inc.
The Action Council
P.O. Box 1695
Columbia, SC 29202
(803) 898-8619
Fax: (803) 898-8624
Contact: Dolores Macey

The Action Council for Cross-Cultural Mental Health and Human Services, Inc., is a voluntary organization dedicated to enhancing the involvement of minority citizens in the management, delivery, and utilization of mental health and human services. A dues-collecting membership organization, the Action Council provides programmatic and policy consultation and training for managers and decisionmakers and promotes education in understanding diverse cultures. The Action Council sponsors an annual conference in conjunction with the South Carolina Department of Mental Health and other organizations.

African American Family Services
2616 Nicollet Avenue South
Minneapolis, MN 55408
(612) 871-7878
Fax: (612) 871-2567
www.aafs.net
Contact: Tasselean Parker

The mission of African American Family Services is to help the African American individual, family, and community reach a greater sense of well-being through the delivery of community- based, culturally specific chemical health, mental health, and family preservation services.

AIDS Mental Health Training Program
UCLA Center for Health Promotion and Disease Prevention
Center for Health Sciences, Room 61-236
10833 LeConte Avenue, Box 951772
Los Angeles, CA 90095-1772
(310) 794-7130
Fax: (310) 206-5717
www.medsch.ucla.edu/aidsinst/education/edprograms/index.html
Contact: Thomas Donohoe

The Center for Mental Health Services-funded AIDS Mental Health Training Program (AMHTP) at UCLA offers HIV knowledge- and skill-based training tailored to mental health providers and health educators who work with people with serious mental illness. AMHTP training programs provide extensive information about HIV and AIDS, as well as experiential training to practice prevention and intervention skills. AMHTP trainings are provided in English and Spanish and address the unique challenges of communicating about and treating HIV-related concerns among mental health service consumers.

American Counseling Association
Association for Multicultural Counseling and Development (AMCD)
P.O. Box 2256
Sacramento, CA 95812-2256
(916) 424-8959
Fax: (916) 424-3985
www.counseling.org/multi_diversity
Contact: Dr. Marcelett Henry

Established in 1972 under the American Counseling Association, the AMCD works to develop an efficient and effective system of organizational management, enhance existing professional standards, and promote and expand culturally competent research and knowledge.

American Psychiatric Association (APA)
Committee on Gay, Lesbian and Bisexual Issues
1400 K Street, NW
Washington, DC 20005
(202) 682-6097
Fax: (202) 682-6837
Contact: Janice Taylor

The APA Committee on Gay, Lesbian and Bisexual Issues is charged to investigate problems and issues that affect the mental health of the gay, lesbian, and bisexual populations, such as discrimination and stigmatization; develop teaching programs to help correct the inadequate training of psychiatrists about homosexual issues; and promote the education of the APA membership and the general public about homosexuality.

American Psychological Association (APA)
Division 44
Society for the Psychological Study of Lesbian,
Gay and Bisexual Issues
729 Boylston Street, 4th Floor
Boston, MA 02116
(617) 262-0315

www.apa.org/about/division/div44.html
Contact: Douglas M. Deville, Psy.D.

The APA Division 44, addressing gay, lesbian, and bisexual concerns, focuses on the diversity of human sexual orientations by supporting research, promoting relevant education, and addressing professional and public policy. It has committees and task forces on accreditation, bisexuality, education, public policy, youth and families, ethnic/racial diversity issues, and science and research. Division 44 publishes a newsletter three times a year and a program describing Division 44's activities for distribution at the annual APA convention.

American Psychological Association
Division 22
Rehabilitation Psychology
Division 22 Administrative Office
750 First Street, NE
Washington, DC 20002-4242
(202) 336-6013
Fax: (202) 218-3599
www.apa.org/divisions/div22
Contact: Dawn Ehde, Ph.D., Membership Chair

The APA Division 22 focuses on the psychological aspects of disability and rehabilitation, providing public information about these issues and promoting high standards and effective practices for professional psychologists in this field. The division publishes a quarterly journal, *Rehabilitation Psychology,* and a quarterly newsletter, *Rehabilitation Psychology News.* Members are involved in clinical service, research, teaching, and administration.

American Psychological Association (APA)
Office of Ethnic Minority Affairs
750 First Street, NE
Washington, DC 20002-4242
(202) 336-5500
Fax: (202) 336-6040
www.apa.org/pi/oema
Contact: Alberto Figueroa

The APA Office of Ethnic Minority Affairs (OEMA) promotes scientific understanding of the influences of culture and ethnicity on behavior, encourages increased public knowledge of the special psychological resources and mental health needs of communities of color, and increases the number and participation of ethnic minority psychologists in the discipline and the Association. In support of these objectives, OEMA's activities include maintaining and editing the *Directory of Ethnic Minority Professionals in Psychology*, operating a minority job bank, and

publishing *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations.*

Asian and Pacific Islander American Health Forum

942 Market Street, Suite 200
San Francisco, CA 94102
(415) 954-9955
Fax: (415) 944-9999
www.apiahf.org
Contact: Tessie Guillermo

Washington, DC, area:
440 First Street, NW, Suite 430
Washington, DC 20001
(202) 624-0007
Fax: (202) 624-9488

A national advocacy, policy, and research organization dedicated to improving the health of Asian and Pacific Islander Americans. The Health Forum offers publications and fact sheets on all aspects of Asian and Pacific Islander health, including mental health. The Forum also maintains a closed and moderated mailing list as an information and referral point for individuals and organizations that provide alcohol, substance abuse, and mental health services.

Association of Asian Pacific Community Health Organizations (AAPCHO)
439 23rd Street
Oakland, CA 94612
(510) 272-9536
Fax: (510) 272-0817
www.aapcho.org
Contact: Jeffery B. Caballero, M.P.H.

The Association of Asian Pacific Community Health Organizations (AAPCHO) is a national association representing community health organizations dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of Asian Americans, Native Hawaiians, and Pacific Islanders within the United States, its territories, and freely associated states, primarily through member community health clinics. Formed in 1987, AAPCHO advocates for policies and programs that will improve the provision of health care services that are community driven, financially affordable, linguistically accessible, and culturally appropriate. As a unified voice of its membership, AAPCHO shares its collective knowledge and experiences with policymakers at the national, state, and local levels.

Center for Hispanic Mental Health Research
Graduate School of Social Service
Fordham University
113 West 60th Street

New York, NY 19923-7484
(212) 636-7085

Fax: (212) 636-7079
Contact: Luis Zayas, Ph.D., Director

Established in 1999 with a grant from the National Institute of Mental Health, the Center for Hispanic Mental Health Research at Fordham University's Graduate School of Social Service conducts applied research focusing on Hispanic populations to generate new knowledge leading to improved mental health services for this growing segment of the U.S. population. Among the center's primary objectives are to conduct epidemiological research identifying the mental health needs of diverse Hispanic groups; conduct studies into ways that standard assessment, treatment, and prevention strategies can be modified to enhance mental health outcomes for Hispanics; conduct psychotherapeutic intervention studies that test the efficacy and effectiveness of new, culturally competent psychosocial services; and disseminate information about research findings through a variety of publications and other forums. In addition, the center is dedicated to increasing the number of researchers, both faculty and students, in the field of mental health. The center's research activities focus on mental health issues that particularly affect Hispanics in the northeastern United States but that also have implications for Hispanic and Latino populations throughout the nation.

Deaf Wellness Center
University of Rochester School of Medicine
Department of Psychiatry
601 Elmwood Avenue
Rochester, NY 14642
(585) 275-3544 (Voice or TTY)
Fax: (585) 273-1117
www.urmc.rochester.edu/smd/psych/Education/psychology/predoc/psycho_deaf.htm
Contact: Robert Q Pollard, Jr., Ph.D., Director

The Deaf Wellness Center, in addition to providing outpatient services to persons who are deaf or hard of hearing in the Rochester, New York, area, serves primarily as a training center for professionals pursuing careers in mental health and deafness. The center trains deaf and sign-proficient hearing individuals for leadership and unusual dedication to excellence in the mental health professions, and it promotes and contributes to such training in other health care professions. The center's primary training objective is to prepare deaf professionals for careers of scholarship and clinical service excellence. The center also trains hearing individuals who work with deaf professionals or deaf consumers, fostering their comprehension of and respect for deaf people and sign language and their ability to work with deaf people in an effective and mutually enriching manner. Training content is informed by the latest relevant research and addresses the spectrum of biological, psychological, social, linguistic, and cultural factors that have an impact on the lives of persons who are deaf.

European Society for Mental Health and Deafness
"Daylesford," Stokeinteignhead, Devon, TQ12 4QD
United Kingdom
+44 1626 873332
Fax: +44 1626 873332

www.esmhd.org/intro-page.html
Contact: Bob Clowes, Executive Director

Much of the current state-of-the-art research and clinical initiatives in the area of mental health and deafness is occurring outside the United States. Prominent among worldwide organizations is the European Society for Mental Health and Deafness (ESMHD), an international nongovernmental organization that promotes the mental health of deaf persons in Europe. In the view of this organization, mental health encompasses the promotion of healthy emotional, psychological, and social development and the prevention and treatment of mental illness and other disorders. ESMHD's primary focus is on people who were born deaf or for whom deafness occurred in early childhood, and whose first or preferred language is sign language. However, the organization is also interested in the mental health of all deaf persons, whatever the age of onset or degree of deafness. ESMHD's goals include encouraging (1) the provision of mental health practices appropriate to deaf people's needs; (2) access to specialized mental health services for deaf persons with mental health problems; (3) specialized habilitation and/or rehabilitation services for deaf people who have been deprived of opportunities for the development or maintenance of life skills; (4) research into mental health and deafness; (5) opportunities for deaf people to provide mental health services for other deaf people; (6) the development of networks of interested people in each country; (7) information collection and dissemination on the mental health care of deaf people; (8) respect for deaf people's language and culture; and (9) exchange of ideas and support among individuals and organizations with an interest in mental health and deafness. ESMHD publications are available from Forest Bookshop, 8 St John St., Coleford, Gloucestershire, GL16 8AR United Kingdom.

Gay, Lesbian, Bisexual and Transgender Health Access Project
Justice Research Institute Health
100 Boylston Street, Suite # 815
Boston, MA 02116
(617) 988-2605
Fax: (617) 988-8708
www.glbthealth.org
Contact: Mary Clark, Director

The Gay, Lesbian, Bisexual and Transgender (GLBT) Health Access Project, in partnership with the Massachusetts Department of Public Health, works to foster the development of comprehensive,

culturally appropriate health promotion policies and health care services for gay, lesbian, bisexual, and transgender people through a variety of venues, including community education, policy development, advocacy, direct service, and prevention programs. GLBT Health Access recently published "Community Standards of Practice for the Provision of Quality Health Care Services for Gay, Lesbian, Bisexual and Transgender Clients." These Community Standards offer detailed guidelines for making health and mental health services accessible and culturally appropriate for GLBT persons. Training and technical assistance regarding the use of these guidelines is provided to service settings throughout Massachusetts through the Fenway Community Health Center.

Georgetown University Child Development Center
National Technical Assistance Center for Children's Mental Health
3307 M Street, NW, Suite 401
Washington, DC 20007
(202) 687-5000
Fax: (202) 687-1954
www.gucdc.georgetown.edu
Contact: Joan Dodge, Ph.D.

The mission of the Georgetown University Child Development Center is to improve the quality of life for children with special needs and their families. Products and services include information packets, issue briefs, and monographs on children and adolescents with serious emotional disturbances; conferences and training institutes on planning, delivery, and financing of services and on increasing cultural competence in mental health service delivery; consultation on systems change and services development and delivery; and agency and organizational collaboration.

Multi-Ethnic Behavioral Health Resource
and Training Center
17 S. High Street, Suite 500
Columbus, OH 43215
(614) 228-2220
Fax: (614) 228-2285
www.mebhc.com
Contact: Marty Miller

The Training Center provides advocacy and training on cultural diversity and mental health issues relevant to the needs of African American, Asian, Hispanic, and Native American residents of Ohio.

National Alliance for Hispanic Health
1501 16th Street, NW
Washington, DC 20036

(202) 387-5000
Fax: (202) 265-8027

www.hispanichealth.org
Contact: Jane Delgado, President

The National Alliance for Hispanic health is the oldest and largest network of health and human service providers, servicing over 10 million Hispanic consumers throughout the United States. Since 1973 the National Alliance for Hispanic Health has grown from a small coalition of visionary mental health providers to a large, dynamic, and strong group of organizations and individuals whose mission is to inform and mobilize consumers; support health and human service providers in the delivery of quality care; improve the science base for accurate decisionmaking; promote appropriate use of technology; and ensure accountability and advocate on behalf of Hispanics.

National Asian American and Pacific Islander Mental Health Association
565 South High Street
Denver, CO 80209
(303) 298-7910
Fax: (303) 298-8180
www.NAAPIMHA.org
Contact: D.J. Ida, Ph.D.

The National Asian American and Pacific Islander Mental Health Association's (NAAPIMHA) mission is to promote the mental health and well-being of Asian Americans and Pacific Islanders. NAAPIMHA advocates on behalf of API mental health issues as well as serves as a forum for effective collaboration and networking between stakeholders of community-based organizations, consumers, family members, service providers, program developers, evaluators, and policy makers representing the various ethnic and regional differences. NAAPIMHA focuses on the following areas, recognizing that cultural competency will be reflected at all levels: (1) enhance collection of appropriate and accurate data; (2) identify current best practices and service models; (3) increase capacity building, which includes providing technical assistance and training of service providers, both professional, and paraprofessional; (4) conduct research and evaluation; and (5) work to engage consumers and families.

National Asian Pacific American Families Against Substance Abuse
340 East Second Street, Suite 409
Los Angeles, CA 90012
(213) 625-5795
Fax: (213) 625-5796
www.napafasa.org

National Asian Pacific American Families Against Substance Abuse (NAPAFASA) is a private, nonprofit, 501(c)(3) membership organization dedicated to addressing mental health and substance abuse concerns of Asian and Pacific Islander populations in the continental United States, Hawaii, the six Pacific Island jurisdictions, and elsewhere. Founded in 1988, NAPAFASA involves service providers, families, and youth in efforts to reach API communities to promote health and social justice and reduce substance abuse and related problems.

National Association of Social Workers (NASW)
National Committee on Lesbian, Gay
and Bisexual Issues (NCLGB)
750 First Street, NE, Suite 700
Washington, DC 20002-4241
(202) 408-8600
Fax: (202) 336-8310
www.socialworkers.org
Contact: Evelyn P. Tomaszewski, ACSW

NCLGB works to promote the development of knowledge, theory and practice as related to gay, lesbian, and bisexual issues; to identify ways to eliminate homophobic social work practices and policies (e.g., so-called reparative therapies); and to assist the association and the larger profession in developing lesbian, gay, and bisexual-affirming policies, procedures, and programs. NASW supports curriculum content that affirms lesbian, gay, and bisexual people; encourages implementation of relevant continuing education; strives for full representation of lesbian, gay, and bisexual people at all levels of leadership and employment in social work; and advocates for and encourages efforts to end violence and discrimination toward gay, lesbian, and bisexual people.

National Center for American Indian and
Alaskan Native Mental Health Research
University of Colorado Health Sciences Center
Department of Psychiatry
4455 East Twelfth Avenue
Campus Box A011-13
Denver, CO 80220
(303) 315-9232
Fax: (303) 315-9579
www.uchsc.edu/sm/ai/ncaianmhr/
Contact: Spero Manson, Ph.D., Director

Funded by the National Institute of Mental Health, the National Center for American Indian and Alaskan Native Mental Health Research focuses on research, research training, information

dissemination, and technical assistance for American Indian and Alaskan Native populations. The Center has developed a computerized bibliography on Indian and Alaskan Native mental health and a resource directory that inventories individuals, programs, and agencies with expertise in mental health research, service, and education specific to Indian and Alaskan Native communities.

National Council of La Raza (La Raza)
111-19th Street, NW, Suite 1000
Washington, DC 20036
(202) 785-1670
Fax: (202) 776-1792
www.nclr.org
Contact: Helen Coronado

La Raza is a private, nonprofit organization established in 1968 to reduce poverty and discrimination and improve opportunities for Hispanic Americans. La Raza works toward this goal primarily through capacity-building assistance to support and strengthen Hispanic community-based organizations; promoting applied research, policy analysis, and advocacy to provide a Hispanic perspective on issues such as education, housing, and health; and encouraging the adoption of programs and policies that equitably serve Hispanics.

National Latino Behavioral Health Association (NLBHA)
P.O. Box 387
Berthoud, CO 80513
(970) 532-7210
Fax: (970) 532-7209
Contact: Marie Sanchez, B.S.W.

The roots for the National Latino Behavioral Health Association began on March 2000 as over 100 key Hispanic community leaders and key partners met at a historical National Congress for Hispanic Mental Health convened by the Substance Abuse and Mental Health Services Administration (SAMHSA). A national agenda and an action plan to improve mental health services for the Latino community were crafted at the Congress. As part of its mission, NLBHA will use the agenda and action plan as guideposts in improving the mental health and substance abuse needs of the Latino population.

National MultiCultural Institute (NMCI)
3000 Connecticut Avenue, NW, Suite 438
Washington, DC 20008-2556
(202) 483-0700
Fax: (202) 483-5233
www.nmci.org

Contact: Elizabeth P. Salett

A nonprofit organization located in Washington, DC, NMCI offers organizational consulting and training—including diversity training and organizational development initiatives—sponsors multicultural conferences, produces educational resource materials, and provides multicultural counseling and referral services.

National Research Center on Asian American Mental Health
Department of Psychology—University of California at Davis
One Shields Avenue
Davis, CA 95616-8686
(530) 752-1400
Fax: (530) 752-3747
http://psychology.ucdavis.edu/asianamerican/
Contact: Stanley Sue, Ph.D.; Nolan Zane, Ph.D.

The National Research Center on Asian American Mental Health (NRCAAMH) was established in 1988 with a grant from the National Institute of Mental Health. NRCAAMH prides itself on being a national and multidisciplinary leader in Asian American and Pacific Islander mental health research. NRCAAMH was founded in response to the need for programmatic research addressing the mental health concerns of Asian Americans and Pacific Islanders. The Center seeks to contribute theoretical and applied research that has an impact on mental health policy and service delivery for Asian Americans and Pacific Islanders.

Office of Minority Health Resource Center
P.O. Box 37337
Washington, DC 20013-7337
(800) 444-6472
Fax: (301) 230-7198
TTY: (301) 230-7199
www.omhrc.gov/omhrc/index.htm
Contact: Jose Tarcisio M. Carneiro, M.P.A., Ed.D.

The Minority Health Resource Center is a national resource and referral service for minority health issues that provides information on funding sources and community programs. The Center's newsletter, *Closing the Gap*, is available free of charge. A customized database searches health resources for African Americans, Asian Americans, Pacific Islanders, Latinos, and Native American populations.

The Program for Research on Black Americans
5062 Institute for Social Research

P.O. Box 1248
Ann Arbor, MI 48106-1248
(734) 763-0045
Fax: (734) 763-0044
www.isr.umich.edu/rcgd/prba
Contact: Susan Frazier-Kouassi, Ph..D.

The Program for Research on Black Americans (PRBA), historically characterized by its vision and innovation, has undertaken a number of important studies focusing on the mental health of African Americans. In 1998, PRBA received funding from the National Institute of Mental Health to create the African American Mental Health Research Program (AAMHRP). The overall objectives of AAMHRP are to introduce a new period of growth and implement a consolidation of the intellectual, scholarly, research, and training capabilities of the PRBA in studying mental health problems and serious mental disorders among African American populations.

TransGender Education Network
JRI Health, TEN
100 Boylston Street, Suite 860
Boston, MA 02116
(617) 988-2605, ext. 211
Fax: (617) 988-2629
www.jri.org/ten.html
Contact: Daviko Marcel, Program Director

TEN is an HIV prevention and health promotion initiative aimed at Greater Boston's transgender community. The project works in three ways: by providing education for medical and human service providers outlining the health and social service needs of transgendered persons; community-building events for the transgender community to foster self-esteem and an awareness of each person's right to medically and culturally appropriate health and social services; and outreach that links transgendered persons to the services and resources they need.

Western Interstate Commission on
Higher Education (WICHE)
Mental Health Program
P.O. Box 9752
Boulder, CO 80301-9752
(303) 541-0250
Fax: (303) 541-0291
www.wiche.edu/mentalhealth/
Contact: Jim Stockdill, Ph..D.

WICHE is a public interstate agency established to promote and facilitate resource sharing, collaboration, and cooperative planning among the western states for higher education and work- force needs. Member and affiliate states include Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming. WICHE has been involved, through contracts with SAMHSA, in key national efforts to improve cultural competence in mental health care services, and was instrumental in efforts to generate standards of care for culturally competent mental health care service provision to members of underserved/underrepresented racial ethnic groups.